

CHAPTER 4  
BASIC PROGRAM BENEFITS

TABLE OF CONTENTS

<u>SECTION</u>	<u>Page</u>
A. General.	4-1
1. Scope of benefits.	4-1
2. Persons eligible for Basic Program benefits.	4-1
3. Authority to act for CHAMPUS.	4-1
4. Status of patient controlling for purposes of cost-sharing.	4-1
5. Right to information.	4-1
6. Physical examinations.	4-2
7. Timely filing of claims.	4-2
8. <b>Double</b> coverage and third party recoveries.	4-2
9. <b>Nonavailability</b> Statements (DD Forms 1251).	4-3
a. Rules applicable to issuance of <b>Nonavailability</b> Statement (DD Form 1251).	4-3
b. Beneficiary responsibility.	4-3
c. Rules in effect at time civilian medical care is provided apply.	4-3
d. <b>Nonavailability</b> Statement (DD Form 1251) must be filed with applicable claim.	4-3
e. <b>Nonavailability</b> Statement ( <b>NAS</b> ) and Claims Adjudication.	4-4
10. Utilization review and quality assurance.	4-4
11. Preauthorization.	4-4
a. Purpose of Preauthorization.	4-4
b. Admissions to authorized institutions requiring preauthorization.	4-4
c. Other preauthorization requirements.	4-5
12. Implementing instructions.	4-5
B. Institutional Benefits.	4-5
1. General.	4-5
a. Billing practices.	4-5
b. Successive inpatient admissions.	4-6
c. Related services and supplies.	4-6
d. Inpatient, appropriate level required.	4-6
e. General or special education not covered.	4-6
2. Covered hospital services and supplies.	4-6
a. Room and board.	4-6
b. General staff nursing services.	4-6
c. ICU.	4-7
d. Operating room, recovery room.	4-7

**SECTION****Page**

e.	Drugs and medicines.	4-7
f.	Durable medical equipment, medical supplies, and dressings.	4-7
g.	Diagnostic services.	4-7
h.	Anesthesia.	4-7
i.	Blood.	4-7
j.	Radiation therapy.	4-7
k.	Physical therapy.	4-7
l.	Oxygen.	4-7
m.	Intravenous injections.	4-7
n.	Shock therapy.	4-7
o.	Chemotherapy.	4-7
p.	Renal and peritoneal dialysis.	4-7
q.	Psychological evaluation tests.	4-8
r.	Other medical services.	4-8
3.	Covered services and supplies provided by special medical treatment institutions or facilities, other than hospitals or RTCs.	4-8
a.	Room and board.	4-8
b.	General staff nursing services.	4-8
c.	Drugs and medicines.	4-8
d.	Durable medical equipment, medical supplies, and dressings.	4-8
e.	Diagnostic services.	4-8
f.	Blood.	4-8
g.	Physical therapy.	4-8
h.	Oxygen.	4-8
i.	Intravenous injections.	4-8
j.	Shock therapy.	4-8
k.	Chemotherapy.	4-9
l.	Psychological evaluation tests.	4-9
m.	Renal and peritoneal dialysis.	4-9
n.	Other medical services.	4-9,
4.	Services and supplies provided by RTCs.	4-9
a.	Room and board.	4-9
b.	Patient assessment.	4-9
c.	Diagnostic services.	4-9
d.	Psychological evaluation tests.	4-9
e.	Treatment of mental disorders.	4-9
f.	Other necessary medical care.	4-9
5.	Extent of institutional benefits.	4-9
a.	Inpatient room accommodations.	4-9
b.	General staff nursing services.	4-10
c.	ICU .	4-11
d.	Treatment. rooms.	4-11
e.	Drugs and medicines.	4-11
f.	Durable medical equipment, medical supplies, and dressings.	4-11
g.	Transitional use items.	4-12
h.	Anesthetics and oxygen.	4-12
i.	Inpatient mental health services.	4-12

SECTIONPage

6.	Emergency inpatient hospital services.	4-13
a.	Existence of medical emergency.	4-13
b.	Immediate admission required.	4-13
c.	Closest hospital utilized.	4-13
c.	Professional Services Benefit.	4-13
1	General.	4-13
a.	Billing practices.	4-14
b.	Services must be related.	4-14
2.	Covered services of physicians and other authorized individual professional providers.	4-14
a.	Surgery.	<del>4-14</del>
b.	Surgical assistance.	4-15
c.	Inpatient medical services.	4-15
d.	Outpatient medical services.	4-15
e.	Psychiatric services.	4-15
f.	Consultation services.	4-15
g.	Anesthesia services.	4-15
h.	Radiation therapy services.	4-15
i.	X-ray services.	4-15
j.	Laboratory and pathological services.	4-15
k.	Physical medicine services or physiatry services.	4-15
1.	Maternity care.	<del>4-15</del>
m.	Well-baby care.	4-15
n.	Other medical care.	4-15
o.	Private duty (special) nursing services.	4-15
p.	Routine eye examinations.	4-16
3.	Extent of professional benefits.	<del>4-16</del>
a.	Multiple surgery.	4-16
b.	Different types of inpatient care, concurrent.	4-16
c.	Need for surgical assistance.	4-17
d.	Aftercare following surgery.	4-17
e.	Cast and sutures, removal.	4-17
f.	Inpatient care, concurrent.	4-17
g.	Consultants who become the attending surgeon.	4-18
h.	Anesthesia administered by the attending physician.	4-18
i.	Treatment of mental disorders.	4-18
j.	Physical and occupational therapy.	4-19
k.	Well-baby care.	4-20
1.	Private duty (special) nursing.	4-21
D.	Other Benefits.	4-23
1.	General.	4-23
2.	Billing practices.	4-24
3.	Other covered services and supplies.	4-24
a.	Blood.	4-24
b.	Durable medical equipment.	4-24
c.	Medical supplies and dressings (consumables).	4-25
d.	Oxygen.	4-25

SECTIONPage

e.	Ambulance.	4	-	2	5
f.	Prescription drugs and medicines.	4-26			
g.	Prosthetic devices .	4-26			
h.	Orthopedic braces and appliances.	4-27			
E.	Special Benefit Information.	4-27			
1.	General.	4-27			
2.	Abortion.	4-27			
3.	Family planning.	4-27			
a.	Birth control (such as contraception).	4-27			
b.	Genetic testing.	4-28			
4.	Treatment of alcoholism.	4-29			
a.	Emergency and inpatient hospital services.	4-29			
b.	Authorized alcoholism treatment.	4-29			
c.	Exclusions.	4-30			
d.	Confidentiality.	4-30			
5.	Organ transplants.	4-30			
a.	Recipient costs.	4-30			
b.	Donor costs.	4-30			
c.	General limitations.	4-31			
d.	Kidney acquisition.	4-31			
e.	Liver Transplants.	4-31			
f.	Heart Transplants.	4-31b			
6.	Eyeglasses, spectacles, contact lenses, or other optical devices.	4-31c			
a.	Exception to general exclusion.	4-31c			
b.	Limitations.	4-32			
7.	Transsexualism or hermaphroditism.	4-32			
8.	Cosmetic, reconstructive, or plastic surgery.	4-32			
a.	Limited benefits under CHAMPUS.	4-33			
b.	General exclusions.	4-33			
c.	Noncovered surgery, all related services and supplies excluded.	4-33a			
d.	Examples of noncovered cosmetic, reconstructive, or plastic surgery procedures.	4-34			
9.	Complications (unfortunate sequelae) resulting from noncovered initial surgery or treatment.	4-35			
10	Dental.	4-35			
a.	Adjunctive dental care, limited.	4-35			
b.	General exclusions.	4-36			
c.	Preauthorization required.	4-36			
d.	Covered oral surgery.	4-36			
e.	Inpatient hospital stay in connection with non-adjunctive, noncovered dental care.	4-36a			
11	Drug abuse.	4-37			
a.	Limitations on who can prescribe drugs.	4-37			
b.	Drug maintenance programs excluded.	4-37			
c.	Kinds of prescription drugs that are monitored carefully by CHAMPUS for possible abuse situations.	4-37			

SECTION

Page

d.	CHAMPUS fiscal intermediary responsibilities.	4-38
e.	Unethical or illegal provider practices related to drugs.	4-38
f.	Detoxification.	4-38
12.	Custodial care.	4-39
a.	Kinds of conditions that can result in custodial care.	4-39
b.	Benefits available in connection with a custodial care case.	4-39
c.	Exception to custodial care exclusion, admission to a hospital.	4-40
d.	Reasonable care for which benefits were authorized or reimbursed before June 1, 1977.	4-40
13.	Domiciliary care.	4-40
a.	Examples of domiciliary care situations.'	4-40
b.	Benefits available in connection with a domiciliary care case.	4-41
c.	<b>General exclusion.</b>	4-41
14.	CT scanning.	4-41
a.	Approved CT scan services.	4-41
b.	Review guidelines and criteria.	4-41
15.	Morbid obesity.	4-41
a.	Conditions for coverage.	4-41
b.	Exclusions.	4-42
16.	Maternity care.	4-42
a.	Benefit.	4-42
b.	Cost-share.	4-42
17.	Biofeedback.	4-42a
a.	Benefits provided.	4-42a
b.	Limitations.	4-42a
c.	Exclusions.	4-42a
d.	Provider requirements.	4-42a
e.	Implementation guidelines.	4-42a
18.	Cardiac Rehabilitation.	4-42a
a.	Benefits provided.	4-42b
b.	Limitations.	4-42b
c.	Exclusions.	4-42b
d.	Provider requirements.	4-42b
e.	Payment.	4-42b
f.	Implementation guidelines.	4-42b
F.	Beneficiary or Sponsor Liability.	4-42b
1.	General.	4-42b
2.	Dependents of active duty members of the Uniformed Services.	4-42c
a.	Annual fiscal year deductible for outpatient services or supplies.	4-42c
b.	Inpatient cost-sharing.	4-43

SECTIONPaRe

c.	Outpatient cost-sharing.	4-44
d.	Ambulatory surgery.	4-44
3.	Retirees, <b>dependents of</b> retirees, dependents of deceased active duty-members, and dependents of deceased retirees.	4-44
a.	Annual fiscal year deductible for outpatient services or supplies.	4-44
b.	Inpatient cost-sharing.	4-45
c.	Outpatient cost-sharing.	4-45
4.	Former spouses.	4-45
a.	Annual fiscal year deductible for outpatient services or supplies.	4-45
b.	Inpatient cost-sharing.	4-45
c.	Outpatient. cost-sharing.	4-46
5.	Cost-sharing under the Military-Civilian Health Services Partnership Program.	4-46
a.	External partnership agreement.	4-46
b.	Internal partnership agreement.	4-46
6.	Amounts over CHAMPUS-determined allowable costs or charges.	4-46
a.	Participating provider.	4-46
b.	Nonparticipating providers.	4-46a
7.	[Reserved]	
8.	Cost-sharing for services provided under special discount arrangements.	4-46a
a.	General rule.	4-46a
b.	Specific applications.	4-46a
G.	Exclusions and Limitations.	4-46b
1.	Not medically or psychologically necessary.	4-46b
2.	Unnecessary diagnostic tests.	4-46b
3.	Institutional level of care.	4-46b
4.	Diagnostic admission.	4-46b
5.	Unnecessary postpartum inpatient stay, mother or newborn.	4-47
6.	Therapeutic absences.	4-47
7.	Custodial care.	4-47
8.	Domiciliary care.	4-47
9.	Rest or rest cures.	4-47
10.	Amounts above allowable costs or charges.	4-47
11.	No legal obligation to pay, <b>no charge would be made.</b>	4-47
12.	Furnished without charge.	4-47
13.	Furnished by local, state, or Federal Government"	4-47
14.	Study, grant, or research programs.	4-47
15.	Not in accordance with accepted standards, experimental or investigational.	4-48
16.	Immediate family, household.	4-48

SECTIONPage

17. Double coverage.	4-48
18. <b>Nonavailability</b> Statement. required.	4-48
19. Preauthorization required.	4-48
20. Psychoanalysis <b>or</b> psychotherapy, part of education.	4-48
21. Runaways.	4-48
22. Services or supplies ordered <b>by</b> a court or other government agency.	4-48
23. Work-related (occupational) disease or injury.	4-48
24. Cosmetic, reconstructive, or plastic <b>surgery</b> .	4-48
25. Surgery, psychological reasons.	4-48
26. Electrolysis.	4-49
27. Dental care.	4-49
28. Obesity, weight. reduction.	4-49
29. Transsexualism or hermaphroditism.	4-49
30. Sexual dysfunctions or inadequacies.	4-49
<b>31.</b> Corns, calluses, and toenails.	4-49
32. Dyslexia.	4-49
33. Surgical sterilization, reversal.	4-49
34. Artificial insemination, in-vitro fertilization, gamete <b>intrafallopian</b> transfer and all other 'similar reproductive technologies.	4-49
35. Nonprescription contraceptives.	4-49
36. Tests to determine paternity or sex of a child.	4-49
37. Preventive care.	4-49
38. Chiropractors and naturopaths.	4-50
39. Counseling.	4-50
40. Acupuncture.	4-50
41. Hair transplants, wigs, or hairpieces.	4-50
a. Benefits provided.	4-50
b. Exclusions.	4-50
42. Education or training.	4-51
43. Reserved.	4-51
44. Exercise.	4-51
45. Audiologist, speech therapist.	4-51
46. Vision care.	4-51
47. Eye and hearing examinations.	4-51
48. Prosthetic devices.	4-51
<b>49.</b> Orthopedic shoes.	4-51
50. Eyeglasses.	4-51
51. Hearing aids.	4-51
52. Telephonic services.	4-51
53. Air <b>conditioners</b> , humidifiers, dehumidifiers, and purifiers.	4-52
54. Elevators or chair lifts.	4-52
55. Alterations.	4-52
56. Clothing.	4-52
57. Food, food substitutes.	4-52

SECTIONPage

58.	Enuresis.	4-52
59.	Reserved.	4-52
60.	Autopsy and postmortem.	4-52
61.	Camping.	4-52
62.	Housekeeper, companion.	4-52
63.	<b>Noncovered</b> condition, unauthorized provider.	4-52
64.	Comfort or convenience.	4-52
65.	"Stop smoking" programs.	4-52
66.	<b>Megavitamin</b> psychiatric therapy, <b>orthomolecular</b> psychiatric therapy.	4-52
67.	Transportation.	4-52
68.	Travel.	4-52
69.	Institutions .	4-52
70.	Supplemental diagnostic services.	4-53
71.	Supplemental consultations.	4-53
72.	Inpatient mental health services.	4-53
73.	Not specifically listed.	4-53
H.	Payment and Liability for Certain Potentially Excludable Services Under the Peer Review Organization Program.	4-53
1.	Applicability.	4-53
2.	Payment for certain potentially excludable expenses.	4-53
3.	Liability for certain excludable services.	4-54
4.	Criteria for determining that beneficiary knew or could reasonably been expected to have known that services were excludable.	4-54
5.	Criteria for determining that provider knew or could reasonably have been expected to have known that that services were excludable.	4-54



Jul 91

CHAPTER 4  
BASIC PROGRAM BENEFITS

A. GENERAL

The CHAMPUS **Basic** Program is essentially a supplemental program to the Uniformed Services direct medical care 'system. The **Basic Program** is similar to private medical insurance programs, and is designed to provide financial assistance to CHAMPUS beneficiaries for certain prescribed medical care obtained from civilian sources.

1. Scope of benefits. Subject to all applicable definitions, conditions, limitations, or exclusions specified in this Regulation, the CHAMPUS Basic Program will pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury, including maternity care **and** well-baby care. Benefits include ~~specified~~ medical services and supplies provided to eligible beneficiaries from authorized civilian sources such as hospitals, other authorized institutional providers, physicians, other authorized individual professional providers, and professional ambulance service, prescription drugs, authorized medical supplies, and rental or purchase of durable medical equipment.

2. Persons eligible for Basic Program benefits. Persons eligible to receive the Basic Program benefits are set forth in Chapter 3 of this Regulation. Any person **determined** to be an eligible CHAMPUS beneficiary is eligible for Basic Program benefits.

3. Authority to act for CHAMPUS. The authority to make benefit determinations and authorize the disbursement of funds under **CHAMPUS** is restricted to the Director, **OCHAMPUS**; designated OCHAMPUS staff; Director, **OCHAMPUSEUR**; or **CHAMPUS** fiscal intermediaries. No other persons or agents (such as physicians, staff members of hospitals, or CHAMPUS health benefits advisors) have such authority.

4. Status of patient controlling for purposes of cost-sharing. Benefits for covered services and supplies described in this chapter will be **extended** either on an inpatient or outpatient cost-sharing basis in accordance with the status of the patient at the time the covered services **and** supplies were provided, unless otherwise specifically designated (such as for **ambulance** service or maternity care). For cost-sharing provisions, refer to section F. of this chapter.

5. Right to information. As a condition precedent to the provision of benefits hereunder, OCHAMPUS or its CHAMPUS fiscal intermediaries shall be entitled to receive information from a physician or hospital or other person, institution, or organization (including a local, state, or U.S. Government agency) providing services or supplies to the beneficiary for which claims or requests for approval for benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, or examination **or** diagnosis of, or treatment rendered, or services and supplies furnished to a beneficiary, and shall be necessary for the accurate and efficient administration of CHAMPUS benefits. Before a determination will be made on a request for **preauthorization** or claim of benefits, a beneficiary or sponsor must provide particular additional information relevant to the requested determina-

tion, when necessary. The recipient of such information shall in every case hold such records confidential except when (a) disclosure of such information is authorized specifically by the beneficiary; (b) disclosure is necessary to permit authorized governmental officials to investigate and prosecute criminal actions, or (c) disclosure is authorized or required specifically under the terms of the Privacy Act or Freedom of Information Act (references (i) through (k)) (refer to section M. of chapter. 1 of this Regulation). For the purposes of determining the applicability of and implementing the provisions of chapters 8, 11 and 12, or any provision of similar purpose of any other medical benefits coverage or entitlement, OCHAMPUS or CHAMPUS fiscal intermediaries may release, without consent or notice to any beneficiary or sponsor, to any person, organization, government agency, provider, or other entity any information with respect to any beneficiary when such release constitutes a routine use published in the Federal Register in accordance with DoD 5400.11-R (reference (k)). Before a person's claim of benefits will be adjudicated, the person must furnish to CHAMPUS information that reasonably may be expected to be in his or her possession and that is necessary to make the benefit determination. Failure to provide the requested information may result in denial of the claim.

6. Physical examinations. The Director, OCHAMPUS, or a designee, may require a beneficiary to submit to one or more medical (including psychiatric) examinations to determine the beneficiary's entitlement to benefits for which application has been made or for otherwise authorized medically necessary services and supplies required in the diagnosis or treatment of an illness or injury (including maternity and well-baby care). When a medical examination has been requested, CHAMPUS will withhold payment of any pending claims or preauthorization requests on that particular beneficiary. If the beneficiary refuses to agree to the requested medical examination, or unless prevented by a medical reason acceptable to OCHAMPUS, the examination is not performed within 90 days of initial request, all pending claims for services and supplies will be denied. A denial of payments for services or supplies provided before (and related to) the request for a physical examination is not subject to reconsideration. The medical examination and required beneficiary travel related to performing the requested medical examination will be at the expense of CHAMPUS. The medical examination may be performed by a physician in a Uniformed Services medical facility or by an appropriate civilian physician, as determined and selected by the Director, OCHAMPUS, or a designee who is responsible for making such arrangements as are necessary, including necessary travel arrangements.

7. Timely filing of claims. All claims submitted for benefits under this chapter must be filed with the appropriate CHAMPUS fiscal intermediary no later than December 31 of the calendar year immediately following the one in which the covered service or supply was rendered. Failure to file a claim timely waives automatically all rights to any benefits for such services or supplies (refer to Chapter 7 of this Regulation).

8. Double coverage and third party recoveries. CHAMPUS claims involving double coverage or the possibility that the United States can recover all or a part of its expenses from a third party, are specifically subject to the provisions of Chapter 8 or Chapter 12 of this Regulation as appropriate.

Jul 91

9. **Nonavailability** Statements (DD Forms 1251). In some geographic locations (or under certain special circumstances), it is necessary for a CHAMPUS beneficiary to determine whether the required medical care can be provided through a Uniformed Service facility. If the required medical care cannot be provided, the hospital commander, or a designee, will issue a **Nonavailability** Statement (DD Form 1251). Except for emergencies, a **Nonavailability** Statement should be issued before medical care is obtained from a civilian source. Failure to secure such a statement may waive the beneficiary's rights to benefits under CHAMPUS.

a. Rules applicable to issuance of **Nonavailability** Statement (DD Form 1251).

(1) The ASD(HA) is responsible for issuing rules and regulations regarding **Nonavailability** Statements.

(2) A **Nonavailability** Statement (NAS) is required for services in connection with nonemergency inpatient hospital care if such services are available **at a** facility of the Uniformed Services located within a **40-mile** radius of the residence of the beneficiary, except that a NAS is not required for services otherwise available at a facility of the Uniformed Services located within a 40-mile radius of the **beneficiary's** residence when another insurance plan or program provides the beneficiary primary coverage for the services.

(3) An NAS is also required for selected outpatient procedures if such services are not available at a Uniformed Service facility (excluding facilities which are exclusively outpatient clinics) located within a 40-mile radius (**catchment area**) of the **residence of the beneficiary. This does not apply to** emergency services or for services for which another insurance plan or program provides the beneficiary primary coverage. Any changes to the selected outpatient procedures will be published in the Federal Register at least 30 days before the effective date of the change by the ASD(HA) and will be limited to the following categories: outpatient surgery and other selected outpatient procedures which have high unit costs and for which care may be available in military treatment facilities generally. The selected outpatient procedures will be uniform for **all** CHAMPUS beneficiaries .

b. Beneficiary responsibility. The beneficiary is responsible for securing information whether or not he or she resides in a geographic area that requires obtaining a **Nonavailability** Statement. Information concerning current rules and regulations may be obtained from the Offices of the Army, Navy, and Air Force Surgeon Generals; or a CHAMPUS health benefits advisor; or the Director, OCHAMPUS, or a designee; or from the appropriate CHAMPUS fiscal intermediary.

c. Rules in effect at time civilian medical care is provided apply. The applicable rules and regulations regarding **Nonavailability** Statements in effect at the time the civilian care is rendered apply in determining whether a **Nonavailability** Statement is required.

d. **Nonavailability** Statement (DD Form 1251) must be filed with applicable claim. When a claim is submitted for CHAMPUS benefits that includes services for which a **Nonavailability** Statement was issued, a valid **Nonavailability** Statement authorization must be on DEERS.

e. Nonavailability Statement (NAS) and claims adjudication.

(1) A NAS is valid for the adjudication of CHAMPUS claims for all related care otherwise authorized by this Regulation which is received from a civilian source while the beneficiary resided within the Uniformed Service facility catchment area which issued the NAS.

(2) A requirement for a NAS for inpatient hospital maternity care must be met for CHAMPUS cost-share of any related outpatient maternity care.

10. Utilization review and quality assurance. Before the extension of any CHAMPUS benefits under the Basic Program as outlined in this chapter, claims submitted for medical services and supplies rendered CHAMPUS beneficiaries are subject to review for quality of care and appropriate utilization. The Director, OCHAMPUS, or a designee, is responsible for utilization review and quality assurance and shall issue such generally accepted standards, norms, and criteria as are necessary to ensure compliance. Such utilization review and quality assurance standards, norms, and criteria shall include, but not be limited to, need for inpatient admission, length of inpatient stay, level of care, appropriateness of treatment, and level of institutional care required. Implementing instructions, procedures, and guidelines may provide for retrospective, concurrent, and prospective review, requiring both in-house and external review capability on the part of both CHAMPUS fiscal intermediaries and OCHAMPUS.

11. Preauthorization. Because CHAMPUS benefits are limited for certain types of care, the beneficiary is required to obtain preauthorization from the Director, OCHAMPUS, or a designee, before the services are provided. The types of care for which preauthorization is required are identified in other parts of this chapter.

a. Purpose of preauthorization. Preauthorization is required for those types of services for which coverage is limited or for which the conditions for coverage are highly technical. In such cases, the likelihood that CHAMPUS benefits will not be available is high. To minimize the risk that beneficiaries will incur costs that CHAMPUS cannot cover, the beneficiary is expected to request preauthorization of the care before the services are received. If a beneficiary fails to obtain preauthorization before receiving the services, the Director, OCHAMPUS, or a designee, may extend CHAMPUS benefits if the services or supplies otherwise would qualify for benefits but for the failure to obtain preauthorization.

b. Admissions to authorized institutions requiring preauthorization. When the Director, OCHAMPUS, requires preauthorization to an inpatient facility, the request for preauthorization is processed by OCHAMPUS or a designee. If the beneficiary elects to proceed with an admission prior to receiving written preauthorization from OCHAMPUS, authorization may be requested subsequently. If the stay in the institution is determined to be appropriate under the provisions of this Regulation, the Director, OCHAMPUS, or a designee, shall authorize benefits retroactively to the date of admission to the institution. If the stay is determined not to qualify under the provisions of this Regulation, the Director, or a designee, shall deny benefits as of the date the care failed to meet the requirements for coverage.

Jul 91

c. Documentation for preauthorization - approved treatment plan. A request for preauthorization described in subsection A.11. of this chapter, requires submission of a detailed treatment plan, in accordance with guidelines and procedures issued by the Director, OCHAMPUS.

d. Other preauthorization requirements

(1.) The Director, OCHAMPUS, or a designee, shall respond to all requests for preauthorization in writing and shall send notification of approval or denial to the beneficiary.

(2) The Director, OCHAMPUS, or a designee, shall specify, in the approved preauthorization, the services and supplies the approval covers.

(3) An approved preauthorization is valid only for 90 days from the date of issuance. If the preauthorized services and supplies are not obtained or commenced within the 90-day period, a new preauthorization request is required.

(4) A preauthorization may set forth other special limits or requirements as indicated by the particular case or situation for which preauthorization is being issued.

12. Implementing instructions. The Director, OCHAMPUS, or a designee, shall issue policies, instructions, procedures, guidelines, standards, or criteria as may be necessary to implement the intent of this Regulation.

B. INSTITUTIONAL BENEFITS

1. General. Services and supplies provided by an institutional provider authorized as set forth in Chapter 6 of this Regulation may be cost-shared only when such services or supplies (i) are otherwise authorized by this Regulation; (ii) are medically necessary; (iii) are ordered, directed, prescribed, or delivered by an OCHAMPUS-authorized individual professional provider as set forth in Chapter 6 of this Regulation or by an employee of the authorized institutional provider who is otherwise eligible to be a CHAMPUS authorized individual professional provider; (iv) are delivered in accordance with generally accepted norms for clinical practice in the United States; (v) meet established quality standards; and (vi) comply with applicable definitions, conditions, limitations, exceptions, or exclusions as otherwise set forth in this Regulation.

a. Billing practices. To be considered for benefits under this section B., covered services and supplies must be provided and billed for by a hospital or other authorized institutional provider. Such billings must be fully itemized and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this Regulation. In the case of continuous care, claims shall be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor or, on a participating basis, directly by the facility on behalf of the beneficiary (refer to Chapter 7).

b. Successive inpatient admissions. Successive inpatient admissions shall be deemed one inpatient confinement for the purpose of computing the active duty dependent's share of the inpatient institutional charges, provided not more than 60 days have elapsed between the successive admissions, except that successive inpatient admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions. For the purpose of applying benefits, successive **admissions** will be determined separately **for** maternity admissions and admissions related to an accidental injury (refer to section F. of this chapter).

c. Related services and supplies. Covered services and supplies must be rendered in connection with and related directly to a covered diagnosis or definitive" Set of. symptoms requiring otherwise authorized medically necessary treatment.

d. Inpatient appropriate level required. For purposes of inpatient care, the level of **institutional** care **for** which Basic Program benefits may be extended must be at the appropriate level required to provide the medically necessary treatment. If an appropriate lower level care facility is adequate, but is not available in the general locality, benefits may be continued in the higher level care facility, but CHAMPUS institutional benefit payments shall be limited to the allowable cost that would have been incurred in **the** appropriate lower level care facility, as determined by the Director, **OCHAMPUS**, or a designee. If it is determined that the institutional care can be provided reasonably in the home setting, no CHAMPUS institutional benefits are payable.

e. General or special education not covered. Services and supplies related to the provision of either regular or special education generally are not covered. Such exclusion applies whether a separate charge is made for education or whether it is included as a part of an overall combined daily charge of an institution. In the latter instance, that portion of the overall combined daily charge related to education must be determined, based on the allowable costs of the educational component, and deleted from the institution's charges before CHAMPUS benefits can **be** extended. The only exception is when appropriate education is not available from or not payable by the cognizant public entity. Each case must be referred to the Director, OCHAMPUS, or a designee, for review and a determination of the applicability of CHAMPUS benefits.

## 2. Covered hospital services and supplies

a. Room and board. Includes special diets, laundry services, and other general housekeeping support services (inpatient only).

b. General staff nursing services.

Jul 91

c. ICU. Includes specialized units, such as for respiratory **conditions**, cardiac surgery, coronary care, burn care, or neurosurgery (inpatient only) .

d. Operating room, recovery room. Operating room and recovery room, including other special treatment rooms and equipment, and hyperbaric chamber.

e. Drugs and medicines. Includes sera, biological, and pharmaceutical preparations (including insulin) that are listed in the official **formularies** of the institution or facility at the time of **use**. (To **be** considered as an inpatient supply, drugs and medicines must be consumed during the specific period the beneficiary is a registered inpatient. Drugs and medicines prescribed for use outside the hospital, even though prescribed and obtained while still a registered inpatient., will **be** considered outpatient supplies and the provisions of section D. of this chapter will apply.)

f. Durable medical equipment, medical supplies, and dressings. Includes durable medical equipment, medical supplies essential to a surgical procedure (such as artificial heart valve and artificial ball and socket joint), sterile trays, casts, and orthopedic hardware. Use of durable medical equipment is restricted to an inpatient basis.

NOTE : If durable medical equipment is to **be** used **on** an outpatient basis or continued in outpatient status after use as an inpatient, benefits will be provided as set forth in section D. of this chapter and cost-sharing will be on an outpatient basis (refer to subsection **A.4.** of this chapter).

g. Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results. Also includes CT scanning under certain limited conditions.

h. Anesthesia. Includes both the anesthetic agent and its **administration**.

i. Blood. Includes blood, plasma and its derivatives, including equipment and supplies, **and its** administration.

j. Radiation therapy. Includes radioisotopes.

k. Physical therapy.

l. Oxygen. Includes equipment for its administration.

m. Intravenous injections. Includes solution.

n. Shock therapy.

o. Chemotherapy.

p. Renal and peritoneal dialysis.

q. Psychological evaluation tests. When required by the diagnosis.

r. Other medical services. Includes such other medical services as may be authorized "by the Director, OCHAMPUS, or a designee, provided they are related directly to the diagnosis or definitive set of symptoms and rendered by a member of the institution's medical or professional staff (either salaried or contractual) and billed for by the hospital.

3. Covered services and supplies provided by special medical treatment institutions or facilities, other than hospitals or RTCS

a. Room and board. Includes special diets, laundry services, and other general housekeeping support services (inpatient only).

b. General staff nursing services.

c. Drugs and medicines. Includes sera, biologicals, and pharmaceutical preparations (including insulin) that are listed in the official formularies of the institution or facility at the time of use. (To be considered as an inpatient supply, drugs and medicines must be consumed during the specific period the beneficiary is a registered inpatient. Drugs and medicines prescribed for use outside the authorized institutional provider, even though prescribed and obtained while still a registered inpatient, will be considered outpatient supplies and the provisions of section D. of this chapter will apply.)

d. Durable medical equipment, medical supplies, and dressings. Includes durable medical equipment, sterile trays, casts, orthopedic hardware and dressings. Use of durable medical equipment is restricted to an inpatient basis.

NOTE : If the durable medical equipment is to be used on an outpatient basis or continued in outpatient status after use as an inpatient, benefits will be provided as set forth in section D. of this chapter, and cost-sharing will be on an outpatient basis (refer to subsection A.4. of this chapter).

e. Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results.

f. Blood. Includes blood, plasma and its derivatives, including equipment and supplies, and its administration.

g. Physical therapy.

h. Oxygen. Includes equipment for its administration.

i. Intravenous injections. Includes solution.

j. Shock therapy.



Jul 91

k. Chemotherapy.

1. Psychological evaluation tests. When required by the diagnosis.

m. Renal and peritoneal dialysis.

n. Other medical services. Other medical services may be authorized by the Director, **OCHAMPUS**, or a designee, provided they are related directly to the diagnosis or definitive set of symptoms and rendered by a member of the institution's medical or professional staff (either salaried or contractual) and billed for by the authorized institutional provider of care.

4. Services and supplies provided by RTCS

a. Room and board. Includes use of residential facilities such as food service (including special diets), laundry services, supervised reasonable recreational and social activity services, and other general services as considered appropriate by the Director, **OCHAMPUS**, or a designee.

b. Patient assessment. Includes the assessment of each child or adolescent accepted by the RTC, including clinical consideration of each of his or her fundamental needs, that is, physical, psychological, chronological age, developmental level, family, educational, social, environmental, and recreational.

c. Diagnostic services. Includes clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results.

d. Psychological evaluation tests.

e. Treatment of mental disorders. Services and supplies that are medically or psychologically necessary to diagnose and treat the mental disorder for which the patient was admitted to the RTC. Covered services and requirements for qualifications of providers are as listed in paragraph C.3.i. of this chapter.

f. Other necessary medical care. Emergency medical services or other authorized medical care may be rendered by the RTC provided it is professionally capable of rendering such services and meets standards required by the Director, **OCHAMPUS**. It is intended, however, that CHAMPUS payments to an RTC should primarily cover those services and supplies directly related to the treatment of mental disorders that require residential care.

5. Extent of institutional benefitsa. Inpatient room accommodations

(1) Semiprivate. The allowable costs for room and board furnished an individual patient are payable for semiprivate accommodations in a hospital or other authorized institution, subject to appropriate cost-sharing

provisions (refer to section F. of this chapter). A semiprivate accommodation is a room containing at least two beds. Therefore, if a room publicly is designated by the institution as a semiprivate accommodation and contains multiple beds, it qualifies as **semiprivate** for the purpose of CHAMPUS.

(2) **Private.** A room with one bed that is designated as a private room by the hospital or other authorized institutional provider. The allowable cost of a private room accommodation is covered only under the following conditions:

(a) When its use is required medically and when the attending physician certifies that a private room is necessary medically for the proper care and treatment of a patient; or

(b) When a patient's medical condition requires **isolation**;  
or

(c) When a patient (in need of immediate inpatient care but not requiring a private room) is admitted to a hospital or other authorized institution that has semiprivate accommodations, but at the time of admission, such accommodations are occupied; or

(d) When a patient is admitted to an acute care hospital (general or special) without semiprivate rooms.

(3) Duration of private room stay. The allowable cost of private accommodations is covered under "the circumstances described in subparagraph B.5.a. (2) of this chapter until the patient's condition no longer requires the private room for medical reasons or medical isolation; or, in the case of the patient not requiring a private room, when a semiprivate accommodation becomes available; or, in the case of an acute care hospital (general or special) which does not have semiprivate rooms, for the duration of an otherwise covered inpatient stay.

(4) Hospital (except an acute care hospital, general or special) or other authorized institutional provider without semiprivate accommodations. When a beneficiary is admitted to a hospital (except an acute care hospital, general or special) or other institution that has no semiprivate accommodations, for any inpatient day when the patient qualifies for use of a private room (as set forth in subparagraphs B.5.a. (2)(a) and (b), above), the allowable cost of private accommodations is covered. For any inpatient day in such a hospital or other authorized institution when the patient does not require medically the private room, the allowable cost of semiprivate accommodations is covered, such allowable costs to be determined by the Director, OCHAMPUS, or a designee.

b. General staff nursing services. General staff nursing services cover all nursing care (other than that provided by private duty nurses) including, but not limited to, general duty nursing, emergency room nursing, recovery room nursing, intensive nursing care, and group nursing arrangements. Only nursing services provided by nursing personnel on the payroll of the hospital or other authorized institution are eligible under this section B. If a nurse who is not on the payroll of the hospital or other

Jul 91

authorized institution is called in specifically to care for a single patient (individual nursing) or more than one patient (group nursing), whether the patient is billed for the nursing services directly or through the hospital or other institution, such services constitute private duty (special) nursing services and are not eligible for benefits under this paragraph (the provisions of paragraph C.2.o. of this chapter would apply),

c. ICU. An ICU is a special segregated unit of a hospital in which patients are **concentrated**, by reason of serious illness, usually without regard to diagnosis. Special lifesaving techniques and equipment are available regularly and immediately within the unit, and patients are under continuous observation by a nursing staff specially trained and selected for the care of this type of patient. The unit is maintained on a continuing, rather than an intermittent or temporary, basis. It is not a postoperative recovery room or a postanesthesia room. In some large or highly specialized hospitals, the ICUs may be refined further for special purposes, such as for respiratory conditions, cardiac surgery, coronary care, burn care, or neurosurgery. For purposes of CHAMPUS, these specialized units would be considered ICUs if they otherwise conformed to the definition of an ICU.

d. Treatment rooms. Standard treatment rooms include emergency rooms, operating rooms, recovery rooms, special treatment rooms, and hyperbaric chambers and all related necessary medical staff and equipment.. To be recognized for purposes of CHAMPUS, treatment rooms must be so designated and maintained by the hospital or other authorized institution on a continuing basis. A treatment room set up on an intermittent or temporary basis would not be so recognized.

e. Drugs and medicines. Drugs and medicines are included as a supply of a hospital or other authorized institution only under the following conditions:

(1) They represent a cost to the facility rendering treatment;

(2) They are furnished to a patient receiving treatment, and **are** related directly to that treatment; and

(3) They are ordinarily furnished by the facility for the care and treatment of inpatients.

f. Durable medical equipment, medical supplies, and dressings. Durable medical equipment, medical supplies, and dressings are included as a supply of a hospital or other authorized institution only under the following conditions:

(1) If ordinarily furnished by the facility for the care and treatment of patients; and

(2) If specifically related to, and in connection with, the condition for which the patient is being treated; and

(3) If ordinarily **furnished** to a patient for use in the hospital or other authorized institution (except in the case of a temporary or disposable item); and

(4) Use of durable medical equipment is limited to those items provided while the patient is an inpatient. If such equipment is provided for use on an outpatient basis, the provisions of section D. of this chapter apply.

**g. Transitional use items.** Under certain circumstances) a temporary or disposable item may be provided for use beyond an inpatient stay, when such item is necessary medically to permit or facilitate the patient's departure from the hospital or other authorized institution, or which may be required until such time as the patient can obtain a continuing supply; or it would be unreasonable or impossible from a medical standpoint to discontinue the patient's use of the item at the time of termination of his or her stay as an inpatient.

h. Anesthetics and oxygen. Anesthetics and oxygen and their administration are **considered** a service or supply if furnished by the hospital or other authorized institution, or by others under arrangements made by the facility under which the billing for such services is made through the facility.

i. Inpatient mental health services. Inpatient mental health services are those **services furnished by** institutional and professional providers for treatment of a nervous or mental disorder (as defined in Chapter 2) to a patient admitted to a CHAMPUS-authorized acute care general hospital; a psychiatric hospital; or, unless **otherwise** exempted, a specialized treatment facility.

(1) Benefits limited to 60 days of inpatient care. CHAMPUS benefits for inpatient care are payable only so long as the inpatient level of care is medically or psychologically necessary and otherwise meets the requirements of this Regulation. In any **case** in which CHAMPUS benefits are paid for inpatient mental health services, such benefits will end automatically when payment has been made for 60 days of covered inpatient mental health services in a calendar year. This benefit limit applies whether the 60 days of paid inpatient mental health services are continuous or intermittent. **or** involve one or more admissions to the same or different inpatient facilities. This limit on inpatient mental health services does not apply to services provided under the provisions of Chapter 5 of this Regulation; services provided on less than a 24-hour-a-day basis; or services provided in an authorized residential treatment center that meets the requirements of paragraph B.4.e. of Chapter 6 of this Regulation.

(2) Director, OCHAMPUS, may grant additional coverage. Upon written request by or on behalf of the beneficiary, the Director, OCHAMPUS, or a designee, taking into account the opinions of professional review, may grant coverage of inpatient mental health services in excess of 60 days in a calendar year when such services are found to be required because of extraordinary medical or psychological circumstances. Coverage in excess of 60 days may be granted if the Director, or a designee, determines that extraordinary medical

Jul 91

or psychological circumstances exist based upon a written request documenting that:

(a) the patient is suffering from an acute mental disorder or an acute exacerbation of a chronic mental disorder that results in the patient being put at significant risk to self or of becoming a danger to others, and the patient requires a type, level, and intensity of otherwise authorized service that can only be provided in an acute care inpatient setting; or

(b) the patient has a serious medical condition apart from his or her psychiatric condition that requires a type, level, and intensity of service that can only be provided in an acute care inpatient setting and the person continues to need psychiatric care, but cannot obtain it on an out-patient basis because of his or her inpatient status. The medical condition and services provided must be otherwise covered under CHAMPUS.

6. Emergency inpatient hospital services. In the case of a medical emergency, benefits can be extended for medically necessary inpatient services and supplies provided to a beneficiary by a hospital, including hospitals that do not meet CHAMPUS standards or comply with the provisions of title VI of the Civil Rights Act (reference (z)), or satisfy other conditions herein set forth. In a medical emergency, medically necessary inpatient services and supplies are those that are necessary to prevent the death or serious impairment of the health of the patient, and that, because of the threat to the life or health of the patient, necessitate, the use of the most accessible hospital available and equipped to furnish such services. The availability of benefits depends upon the following three separate findings and continues only as long as the emergency exists, as determined by medical review. If the case qualified as an emergency at the time of admission to an unauthorized institutional provider and the emergency subsequently is determined no longer to exist, benefits will be extended up through the date of notice to the beneficiary and provider that CHAMPUS benefits no longer are payable in that hospital.

a. Existence of medical emergency. A determination that a medical emergency existed with regard to the patient's condition;

b. Immediate admission required. A determination that the condition causing the medical emergency required immediate admission to a hospital to provide the emergency care; and

c. Closest hospital utilized. A determination that diagnosis or treatment was received at the most accessible (closest) hospital available and equipped to furnish the medically necessary care.

c. PROFESSIONAL SERVICES BENEFIT

1. General. Benefits may be extended for those covered services described in this section C., that are provided in accordance with good medical practice and established standards of quality by physicians or other authorized individual professional providers, as set forth in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, exceptions, limitations, or exclusions as may be otherwise set forth

in this or other chapters of this Regulation. Except as otherwise specifically authorized, to be considered for benefits under this section C., the described services must be rendered by a physician, or prescribed, ordered, and referred medically by a physician to other authorized individual professional providers. **Further**, except under specifically defined circumstances, there **should** be an attending physician in any episode of care. (For example, certain services of a clinical psychologist are exempt from this requirement. "For these exceptions, refer to Chapter 6.)

a. **Billing practices.** To be considered for benefits under this section C., covered professional services must be performed personally by the physician or other authorized individual professional provider, who is other than a salaried or contractual staff member of a hospital or other authorized institution, and who ordinarily and customarily bills on a **fee-for-service** basis for professional services rendered. Such billings must be itemized fully and sufficiently descriptive to permit CHAMPUS to determine whether benefits are authorized by this Regulation. For continuing **professional** care, claims **should** be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days either by the beneficiary or sponsor, or directly by the physician or other authorized individual professional provider on behalf of a beneficiary (refer to Chapter 7 of this Regulation).

b. **Services must be related.** Covered professional services must be rendered in connection with and directly related to a covered diagnosis or definitive set of symptoms requiring medically necessary treatment.

2. **Covered services of physicians and other authorized individual professional providers**

a. **Surgery.** Surgery means operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and the following procedures:

- Bronchoscopy
- Laryngoscopy
- Thoracoscopy
- Catheterization of the heart
- Arteriograph thoracic lumbar
- Esophagoscopy
- Gastrosocopy
- Proctoscopy
- Sigmoidoscopy
- Peritoneoscopy
- Cystoscopy
- Colonoscopy
- Upper G.I. panendoscopy
- Encephalograph
- Myelography
- Discography
- Visualization of intracranial aneurysm by intracarotid injection of dye, with exposure of carotid artery, unilateral

**Ventriculography**

**Insufflation** of uterus-and fallopian tubes for determination of tubal patency (**Rubin's** test of injection of **radiopaque** medium or for dilation)

Introduction of opaque media into the cranial arterial. system, preliminary to cerebral **arteriography**, or into vertebral and **subclavian** systems

**Intraspinal** introduction of air preliminary to **pneumoencephalography**

**Intraspinal** introduction of opaque media preliminary to **myelography**

**Intraventricular** introduction of air preliminary to **ventriculography**

NOTE: The Director, OCHAMPUS, or a designee, shall determine such additional procedures that may **fall** within the intent of this definition of "surgery."

- b. Surgical assistance.
- c. Inpatient medical services.
- d. Outpatient medical services.
- e. Psychiatric services.
- f. Consultation services.
- g. Anesthesia services.
- h. Radiation therapy services.
- i. X-ray services.
- j. Laboratory and pathological services.
- k. Physical medicine services or **physiatry** services.
- l. Maternity care.
- m. Well-baby care.

n. Other medical care. Other medical care includes, but is not limited to, **hemodialysis**, inhalation therapy, shock therapy, and chemotherapy. The Director, OCHAMPUS, or a designee, shall determine these additional medical services for which benefits may be extended under this paragraph.

NOTE : A separate professional charge for the oral administration of approved antineoplastic drugs is not covered.

- o. Private duty (special) nursing services.

p" Routine eye examinations. Coverage for routine eye examinations is limited to dependents of active duty members, to one examination per calendar year per person, and to services rendered on or after October 1, 1984.

3. Extent of professional benefits

a. Multiple surgery. In cases of multiple surgical procedures performed at the same time, benefits shall be determined as follows:

(1) If such multiple surgical procedures are for related conditions (whether or not, as in the case of cutting procedures, such care is performed through the same surgical opening or by the same surgical approach), benefits shall be limited to that part of the surgical care for which the greatest amount is payable under the applicable reimbursement method (refer to section E. of Chapter 6 of this Regulation). For the purposes of CHAMPUS, all procedures performed through the same surgical approach shall be considered to be related conditions.

(2) If the multiple surgical procedures are for unrelated conditions, benefits shall be **extended** as follows:

(a) 100 percent of the CHAMPUS-determined allowable charge for the major surgical procedure; and

(b) 50 percent of the CHAMPUS-determined allowable charge for each of the other surgical procedures; **or**

(c) Except that, if the multiple surgical procedures involve the fingers or toes, benefits for the first surgical procedure shall be at 100 percent of the CHAMPUS-determined allowable charge; the second at 50 percent; and the third and subsequent at 25 percent.

b. Different types of inpatient care, concurrent. If a beneficiary receives inpatient medical care during the same admission in which he or she also receives surgical care **or** maternity care, the beneficiary **shall be** entitled to the greater of the CHAMPUS-determined allowable charge for either the inpatient medical care or surgical or maternity care received, as the case may be, but not 'both; except that the provisions of this paragraph **C.3.b.** shall **not** apply if such inpatient medical care is for a diagnosed condition requiring inpatient. medical care not related to the condition for which surgical care or maternity care is received, and is received from a physician other than the one rendering the surgical care or maternity care.

NOTE : This provision is not meant to imply that when extra time and special effort are required due to postsurgical or postdelivery complications, the attending physician may not request special consideration for a higher than usual charge.



Jul 91

c. Need for surgical assistance. Surgical assistance is payable only when the complexity of the procedure warrants a surgical assistant (other than the surgical nurse or other such operating room personnel), subject to utilization review. In order for benefits to be extended for surgical assistance service, the primary surgeon may be required to certify in writing to the nonavailability of a qualified intern, resident, or other house physician. When a claim is received for a surgical assistant involving the following circumstances, special review is required to ascertain whether the surgical assistance service meets the medical necessity and other requirements of this section C.

(1) If the surgical assistance occurred in a hospital that has a residency program in a specialty appropriate to the surgery;

(2) If the surgery was performed by a team of surgeons;

(3) If there were multiple surgical assistants; or

(4) If the surgical assistant was a partner of or from the same group of practicing surgeons as the attending surgeon.

d. Aftercare following surgery. Except for those diagnostic procedures classified as surgery in this section C., and injection and needling procedures involving the joints, the benefit payments made for surgery (regardless of the setting in which it is rendered) include normal aftercare, whether the aftercare is billed for by the physician or other authorized individual professional provider on a global, all-inclusive basis, or billed for separately.

e. Cast and suture removal. The benefit payments made for the application of a cast or of sutures normally covers the postoperative care including the removal of the cast or sutures. When the application is made in one geographical location and the removal of the cast or sutures must be done in another geographical location, a separate benefit payment may be provided for the removal. The intent of this provision is to provide a separate benefit only when it is impracticable for the beneficiary to use the services of the provider that applied the cast originally. Benefits are not available for the services of a second provider if those services reasonably could have been rendered by the individual professional provider who applied the cast or sutures initially.

f. Inpatient care, concurrent. Concurrent inpatient care by more than one individual professional provider is covered if required because of the severity and complexity of the beneficiary's condition or because the beneficiary has multiple conditions that require treatment by providers of different specialties. Any claim for concurrent care must be reviewed before extending benefits in order to ascertain the condition of the beneficiary at the time the concurrent care was rendered. In the absence of such determination, benefits are payable only for inpatient care rendered by one attending physician or other authorized individual professional provider.

g. Consultants who become the attending surgeon. A consultation performed within 3 days of surgery by the attending physician is considered a preoperative examination. Preoperative examinations are an integral part of the surgery and a separate benefit is not payable for the consultation. If more than 3 days elapse between the consultation and surgery (**performed by** the same physician), benefits may **be** extended for the consultation, subject to review.

h. Anesthesia administered by the attending physician. A separate benefit is not payable **for** anesthesia administered **by** the attending physician (surgeon or obstetrician) **or** dentist, or by the surgical, obstetrical, or dental **assistant**.

i. Treatment of mental disorders. CHAMPUS benefits for the treatment of mental disorders are payable for beneficiaries who are outpatients or inpatients of CHAMPUS-authorized general or psychiatric hospitals, **RTCs**, or specialized treatment facilities, as authorized by the Director, **OCHAMPUS**, or a designee. All such services are subject to review for medical or psychological necessity and for quality of care. The Director, **OCHAMPUS**, reserves the right to require **preauthorization** of mental health services. Preauthorization may **be** conducted by the Director, **OCHAMPUS**, **or** a designee.

(1) Covered diagnostic and therapeutic services. Subject to the requirements and limitations stated, CHAMPUS benefits are payable for the following services when rendered in the diagnosis or treatment of a covered mental disorder by a CHAMPUS-authorized, qualified mental health provider practicing within the scope of his or her license. Qualified mental health providers are: psychiatrists or other physicians; clinical psychologists, certified psychiatric nurse specialists or clinical social workers; and marriage and family, pastoral, and mental health counselors, under a physician's supervision. No payment will be made for any service listed in this subparagraph **C.3.i.(1)** rendered **by** an individual who does not meet the criteria of Chapter 6 of this Regulation for his or her respective profession, regardless of whether the provider is an independent professional provider or an employee of an authorized professional or institutional provider.

(a) Individual psychotherapy, adult or child. A covered individual **psychotherapy session** is no more than 60 minutes in length. An individual psychotherapy session of up to 120 minutes in length is payable for crisis intervention.

(b) Group psychotherapy. A covered group psychotherapy session is no more than 90 minutes in length.

(c) Family or conjoint psychotherapy. A covered family or conjoint psychotherapy session is no more than 90 minutes in length. A family or conjoint psychotherapy session of up to 180 minutes in length is payable for crisis intervention.

(d) Psychoanalysis. Psychoanalysis is covered subject to specific review for medical or psychological necessity and appropriateness by the Director, **OCHAMPUS**, or a designee.

(e) Psychological testing and assessment.

(f) Administration of psychotropic drugs. When prescribed by an authorized provider qualified by licensure to prescribe drugs.

(g) Electroconvulsive treatment. When provided in accordance with guidelines issued by the Director, OCHAMPUS.

(h) Collateral visits. Covered collateral visits are those that are medically or psychologically necessary for the treatment of the patient and, as such, are considered as a psychotherapy session for purposes of subparagraph C.3.i. (2) of this chapter.

(2) Limitations and review requirements

(a) Outpatient psychotherapy. Outpatient psychotherapy generally is limited to a maximum of two psychotherapy sessions per week, in any combination of individual, family, conjoint, collateral, or group sessions. Before benefits can be extended for more than two outpatient psychotherapy sessions per week, professional review of the medical or psychological necessity for and appropriateness of the more intensive therapy is required.

(b) Inpatient psychotherapy. Coverage of inpatient psychotherapy is based on the medical or psychological necessity for the services identified in the patient's treatment plan. As a general rule, up to five psychotherapy sessions per week are considered appropriate. Additional sessions per week or more than one type of psychotherapy session performed on the same day (for example, an individual psychotherapy session and a family psychotherapy session on the same day) could be considered for coverage, depending on the medical or psychological necessity for the services. Benefits for inpatient psychotherapy will end automatically when the patient has received 60 days of covered inpatient mental health services in a calendar year, unless additional coverage is granted by the Director, OCHAMPUS. The Director, OCHAMPUS, shall issue specific guidelines for reviewing the medical and psychological necessity for and the quality of inpatient psychotherapy.

(3) Covered ancillary therapies. Includes art, music, dance, occupational, and other designated ancillary therapies, when included by the attending provider in an approved inpatient or outpatient treatment plan.

(4) Review of claims for treatment of mental disorder. The Director, OCHAMPUS, shall establish and maintain procedures for review, including professional review, of the services provided for the treatment of mental disorders.

j. Physical and occupational therapy

(1) Physical therapy. To be covered, physical therapy must be related to a covered medical condition. If performed by other than a physician, a physician (or other authorized individual professional provider acting within the scope of their license) shall

refer the patient **for** treatment and supervise the physical therapy. Generally, coverage of outpatient physical therapy is limited to a 60-day period, at up to two physical therapy sessions per week. Physical therapy beyond this length or frequency requires documentation **of the** medical necessity for the therapy and the anticipated results of the therapy. General exercise programs are not covered, even if recommended by a physician and conducted by qualified personnel. Passive exercises and range of motion exercises are not covered except when prescribed as an integral part of a comprehensive program of physical therapy.

(2) Occupational therapy. To be covered, occupational therapy must be related to a covered medical condition and must be directed to assisting the patient to overcome or compensate for disability resulting from illness, injury, or the effects of treatment of a covered condition. If performed by other than a physician, a physician shall prescribe the treatment and a physician shall supervise the occupational therapy. The occupational therapist providing the therapy shall be an employee of a **CHAMPUS-authorized** institutional provider and the services must be rendered in connection with CHAMPUS authorized care. Only those occupational therapy services that are rendered as part **of** an organized inpatient or outpatient rehabilitation program are covered. Occupational therapists are not. considered **CHAMPUS-authorized** providers in their own right and may not submit bills on a fee-for-service basis. The employing institutional provider shall bill for the services of the occupational therapist.

k. Well-baby care. Benefits routinely are payable for well-baby care from birth up to the child's second birthday.

(1) The following services are payable when rendered as a part of a specific well-baby care program and when rendered by the attending pediatrician, family physician, **or** a pediatric nurse practitioner:

- (a) Newborn examination, PKU tests, and newborn circumcision.
- (b) History, physical examination, discussion, and counseling.
- (c) Vision, hearing, and dental screening.
- (d) Developmental appraisal.
- (e) Immunization (that is, DPT, polio, measles, mumps, and rubella) .
- (f) Tuberculin test, hematocrit or **Hgb.**, and urinalysis.

(2) Additional services or visits required because of specific findings or because of the particular circumstance of the individual case **are** covered if medically necessary and otherwise authorized for benefits under CHAMPUS.

Jul 91

1. Private duty (special) nursing. Benefits are available for the skilled nursing services rendered by a **private** duty (special) nurse to a beneficiary requiring intensive skilled nursing care that can only be provided with the technical proficiency and scientific skills of an R.N. The specific skilled nursing services being rendered are controlling, not the condition of the patient or the professional status of the private duty (special) nurse rendering the services.

(1) Inpatient private **duty** (special) nursing services are limited to those rendered to an inpatient in a hospital that does not have an **ICU**. In **addition**, under specified circumstances, private duty (special) nursing in the home setting also is covered.

(2) The private duty (special) nursing care must be ordered and certified to **be** medically necessary by the attending physician.

(3) The skilled nursing care must be rendered by a private duty (special) nurse who is neither a **member** of the immediate family nor is a member of the beneficiary's household.

[RESERVED]

Jul 91

(4) Private duty (special) nursing care does not, except incidentally, include providing services that provide or support primarily the essentials of daily living or acting as a companion or sitter.

(5) If the private duty (special) nursing care services being performed are primarily those that could be rendered by the average adult with minimal instruction or supervision, the services **would** not qualify as covered private duty (special) nursing services, 'regardless of whether performed by an R.N., regardless of whether or not ordered and certified to by the attending physician, and regardless of the condition of the patient.

(6) In order for such services to be considered for benefits, a private duty (special) nurse is required to maintain detailed daily nursing notes, whether the case involves inpatient nursing service or nursing services rendered in the home setting.

(7) Claims for continuing private duty (special) nursing care shall be submitted at least every 30 days. Each claim will be reviewed and the nursing care evaluated whether it continues to be appropriate and eligible for benefits.

(8) In most situations involving private duty (special nursing care rendered in the home setting, benefits will be available only for a portion of the care, that is, providing benefits only for that time actually required to perform medically necessary skilled nursing services. If full-time private duty (special) nursing services are engaged, usually for convenience or to provide personal services to the patient, CHAMPUS benefits are payable only for that portion of the day during which skilled nursing services are rendered, but in no event is less than 1 hour of nursing care payable in any 24-hour period during which skilled nursing services are determined to have been rendered. Such situations often are better accommodated through the use of visiting nurses. This allows the personal services that are not **coverable** by CHAMPUS to be obtained at lesser cost from other than an R.N. Skilled nursing services provided by visiting nurses are covered under CHAMPUS .

NOTE : When the services of an R.N. are not available, benefits may be extended for the otherwise covered services of a **L.P.N.** or **L.V.N.**

#### D. OTHER BENEFITS

1. General. Benefits may be extended for the allowable charge of those other covered **services** and supplies described in this section D., which are provided in accordance with good medical practice and established standards of quality by those other authorized providers described in Chapter 6 of this Regulation. Such benefits are subject to all applicable definitions, conditions, limitations, or exclusions as otherwise may be set forth in this or other chapters of this Regulation. To be considered for benefits under this section D., the described services or supplies must be prescribed and ordered by a physician. Other authorized individual professional providers acting within their scope of licensure may also prescribe and order these services and supplies unless otherwise specified in this section D. For example, durable medical equipment and cardiorespiratory monitors can only be ordered by a physician.

2. Billing practices. To be considered for benefits under this Section D., covered services and supplies must be provided and billed for by an authorized provider as set forth in Chapter 6 of this Regulation. Such billing must be itemized fully and described **sufficiently**, even when CHAMPUS payment is determined under the CHAMPUS DRG-based payment system, so that CHAMPUS can determine whether benefits are authorized by this Regulation. Except for claims subject to the CHAMPUS **DRG-based** payment system, whenever continuing charges are involved, claims should be submitted to the appropriate CHAMPUS fiscal intermediary at least every 30 days (monthly) either by the beneficiary or sponsor or directly by the provider. For claims subject to the CHAMPUS **DRG-based** payment system, claims may be submitted only after the beneficiary has been discharged or transferred from the hospital.

3. Other covered services and supplies

a. Blood. If whole blood or plasma (or its derivatives) are provided and billed for by an authorized institution, in connection with covered treatment., benefits are extended as set forth in section B. of this chapter. If blood is billed for directly to a beneficiary, benefits may be extended under this section D. in the same manner as a medical supply.

b. Durable medical equipment

(1) Scope of benefit. Subject to the exceptions in paragraphs (2) and (3) below, only durable medical equipment (DME) which is ordered by a physician for the specific use of the beneficiary, and which complies with the definition of "Durable Medical Equipment" in Chapter 2 of this Regulation, and which is not otherwise excluded by this Regulation qualifies as a Basic Program benefit.

(2) Cardiorespiratory monitor exception.

(a) When prescribed by a physician who is otherwise eligible as a CHAMPUS individual professional provider, or who is on active duty with a United States Uniformed Service, an electronic cardiorespiratory monitor, including technical support necessary for the proper use of the monitor, may be cost-shared as durable medical equipment when supervised by the prescribing physician for in-home use by:

1 An infant beneficiary who has had an apparent life-threatening event, as defined in guidelines issued by the Director, OCHAMPUS, or a designee, or,

2 An infant beneficiary who is a subsequent or multiple birth biological sibling of a victim of sudden infant death syndrome (SIDS), or,

3 An infant beneficiary whose birth weight was 1,500 grams or less, or,

4 An infant beneficiary who is a pre-term infant with pathologic apnea, as defined in guidelines issued by the Director, OCHAMPUS, or a designee, or,



5 Any beneficiary who has a condition or suspected condition designated in guidelines issued by the Director, **OCHAMPUS**, or designee, for which the in-home use of the **cardiorespiratory** monitor otherwise meets Basic Program requirements.

(b) The following types of services and items may be cost-shared when provided in conjunction with an otherwise authorized **cardiorespiratory** monitor:

1 Trend-event recorder, including technical support necessary for the proper use of the recorder.

2 Analysis of recorded physiological data associated with monitor alarms.

3 Professional visits for services otherwise authorized by this Regulation, and for family training on how to respond to an apparent life-threatening event.

4 Diagnostic testing otherwise authorized by this Regulation.

(3) Basic equipment exception. A wheelchair, or a CHAMPUS-approved alternative, which is medically necessary to provide basic mobility, including reasonable additional cost for medically necessary modifications to accommodate a particular disability, may be cost-shared as durable medical equipment.

(4) Exclusions. DME which is otherwise qualified as a benefit is excluded as a benefit under the following circumstances:

(a) DME for a beneficiary who is a patient in a type of facility that ordinarily provides the same type of DME item to its patients at no additional charge in the usual course of" providing its services.

(b) DME which is available to the beneficiary from a Uniformed Services Medical Treatment Facility.

(c) DME with deluxe, luxury, or immaterial features which increase the cost of the item to the government relative to similar item without those features.

(5) Basis for reimbursement. The cost of DME may be shared by the CHAMPUS based upon the price **which** is most advantageous to the government taking into consideration the anticipated duration of the medically necessary need for the equipment and current price information for the type of item. The cost analysis must include a comparison of the total price of the item as a monthly rental charge, a lease-purchase price, and a lump-sum purchase price and a provision for the time **value** of money at the rate determined by the U.S. Department of the Treasury.

Jul 91

c. Medical supplies and dressings (consumables). Medical supplies and . . . . dressings (consumables) are those that do not withstand prolonged, repeated use. Such items must be related directly to an appropriate and verified covered medical condition of the specific beneficiary **for** whom the item was purchased and obtained from a medical supply company, **a** pharmacy, or authorized institutional provider. Examples of covered medical supplies and dressings are disposable syringes for a known diabetic, colostomy sets, irrigation sets, and elastic bandages. An external surgical garment specifically designed for use following a mastectomy is considered a medical **supply** item.

NOTE : Generally, the allowable charge of a medical supply item will be under **\$100**. Any item over this amount must be reviewed to determine whether " it would not qualify as a DME item. If it is, in fact, a medical supply item and does not represent. an excessive charge, it can be considered for benefits under paragraph D.3.c., above.

d. Oxygen. Oxygen and equipment for its administration are covered. Benefits are limited to providing a tank unit at one location with oxygen limited to a 30-day supply at any one time. Repair and adjustment of **CHAMPUS-purchased** oxygen equipment also is covered,

e. Ambulance. Civilian ambulance service to, from, and between hospitals is covered when medically necessary in connection with otherwise covered services and supplies and a covered medical condition. Ambulance service also is covered for transfers to a Uniformed Service Medical Treatment Facility (**USMTF**). For the purpose of CHAMPUS payment, ambulance service is an outpatient service (including in connection with maternity care) with the exception of otherwise covered transfers between hospitals which are cost-shared on an inpatient basis. Ambulance transfers from a hospital based emergency room to another hospital more capable of providing the required care **will** also be cost-shared **on** an inpatient basis.

NOTE : The inpatient cost-sharing provisions for ambulance" transfers only apply to otherwise covered transfers between hospitals; i.e., acute care, general, and special hospitals; psychiatric hospitals; and lung-term hospitals.

(1) Ambulance service is covered for emergency transfers from a beneficiary's place of residence, accident scene, or other location to a **USMTF**, and for transfer to a **USMTF** after treatment at, or admission to, a civilian hospital, if ordered by other than a representative! of the **USMTF**.

(2) Ambulance service cannot be used instead of taxi service and is not payable when the patient's condition would have permitted use of regular private transportation; nor is it payable when transport or transfer of a patient is primarily for the purpose of having the patient nearer to home, family, friends, or personal physician. Except as described in subparagraph **D.3.e.** (1), above, transport must be to closest appropriate facility by the least costly means.

(3) Vehicles such as **medicabs** or **ambicabs** function primarily as public passenger conveyances transporting patients to and from their medical appointments. No actual medical care is provided to the patients in transit. These types of vehicles do not qualify for benefits for the purpose of CHAMPUS payment.

(4) Ambulance services by other than land vehicles (such as a boat or airplane) may be considered only when the pickup point is inaccessible by a land vehicle, or when great distance or other obstacles are involved in transporting the patient to the **nearest hospital** with appropriate facilities and the patient's medical condition warrants speedy admission or is such that transfer by other means is contraindicated,

f. Prescription drugs and medicines. Prescription drugs and medicines that by U.S. law require a physician's or other authorized individual professional **provider's prescription** (acting within the scope of their license) and that are ordered or prescribed by a physician or other authorized individual professional provider (except that insulin is covered for a known diabetic, even though a prescription may not be required for its purchase) in connection with an otherwise covered condition or treatment, including Rh immune globulin.

(1) Drugs administered by a physician or other authorized individual professional provider as an integral part of a procedure covered under sections B. or C. of this chapter (**such** as chemotherapy) are not covered under this subparagraph inasmuch as the benefit for the institutional services or the professional services in connection with the procedure itself also **includes** the drug used.

(2) CHAMPUS benefits may not be extended for drugs not approved by the U.S. Food and Drug Administration for general use by humans (even though approved for testing with humans).

g. Prosthetic devices. The purchase of prosthetic devices is limited to artificial limbs and eyes, except those items that are inserted surgically into the body as an essential and integral part of an otherwise covered surgical **procedure** are not excluded.

NOTE : In order for CHAMPUS benefits to be extended, any surgical **implant** must **be** approved for use in humans by the U.S. Food and Drug Administration. Devices that are approved only for **investigational** use" in humans are not payable.

h. Orthopedic braces and appliances. The purchase of leg **braces** (including attached shoes), arm braces, back braces, and neck braces is covered. Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet., including special-ordered, custom-made built-up shoes or regular shoes subsequently built up, are not covered.

E. SPECIAL BENEFIT INFORMATION

1. General. There are certain circumstances, conditions, or limitations that - impact the extension of benefits and that require special emphasis and explanation. This section E. sets forth those benefits and limitations recognized to **be** in this category. The benefits and limitations herein described also are subject to **all** applicable definitions, conditions, limitations, exceptions, and exclusions as set forth in **this** or other chapters of this Regulation, except as otherwise may be provided specifically in this section E.

2. Abortion.. The statute under which CHAMPUS operates prohibits payment for abortions with one single exception--where the **life** of the woman would be endangered if the fetus were carried to term. Covered abortion services are limited to medical services and supplies only. Physician certification is required attesting that the abortion was performed because the mother's life would have **been** endangered if the fetus were carried to term. Abortions performed for suspected or confirmed fetal **abnormality** (e.g., **anencephalic**) or for mental health reasons (e.g., threatened suicide) do not fall within the exceptions permitted within the language of the statute and are **not** authorized for payment under CHAMPUS.

NOTE : Covered abortion services are limited to medical services or supplies **only** for the single circumstance outlined above and do not include abortion counseling or referral fees. Payment is not allowed for any services involving preparation for, or normal' **followup** to, a noncovered abortion. The Director, OCHAMPUS, or a designee, shall issue guidelines describing the **policy** on abortion.

3. Family planning. The scope of the CHAMPUS family planning benefit is as follows:

a. Birth control (such **as** contraception)

(1) Benefits provided. Benefits are available for services and supplies related to preventing conception, including the following:

(a) Surgical insertion, removal, or replacement of intrauterine devices.

(b) Measurement for, and purchase of, contraceptive diaphragms (and later remeasurement and replacement).

(c) Prescription oral contraceptives.

(d) Surgical sterilization (either male or female).

(2) Exclusions. The family planning benefit does not include the following:

(a) Prophylactics (condoms).

(b) Spermicidal foams, jellies, and sprays not requiring a prescription.

(c) Services and supplies related to noncoital reproductive technologies, including but not limited to artificial insemination (including any costs related to donors or semen banks), in-vitro fertilization and gamete intrafallopian transfer.

(d) Reversal of a surgical sterilization procedure (male or female).

b. Genetic testing. Genetic testing essentially is preventive rather than related to active medical treatment of an illness or injury. However, under the family planning benefit, genetic testing is covered when performed in certain high risk situations. For the purpose of CHAMPUS, genetic testing includes tests to detect developmental abnormalities as well as purely genetic defects.

(1) Benefits provided. Benefits may be extended for genetic testing performed on a pregnant beneficiary under the following prescribed circumstances. The tests must be appropriate to the specific risk situation and must meet one of the following criteria:

(a). The mother-to-be is 35 years old or older; or

(b) The mother- or father-to-be has had a previous child born with a congenital abnormality; or

(c) Either the mother- or father-to-be has a family history of congenital abnormalities; or

(d) The mother-to-be contracted rubella during the first trimester of the pregnancy; or

(e) Such other specific situations as may be determined by the Director, OCHAMPUS, or a designee, to fall within the intent of this paragraph E.3.b.

(2) Exclusions. It is emphasized that routine or demand genetic testing is not covered. Further, genetic testing does not include the following:

(a) Tests performed to establish paternity of a child.

(b) Tests to determine the sex of an unborn child.

4. Treatment of alcoholism. Emergency and inpatient hospital care for complications of alcoholism and detoxification are covered as for any other medical condition. Specific coverage for the treatment of alcoholism includes detoxification, rehabilitation, and **outpatient** care provided in authorized alcohol rehabilitation facilities.

a. Emergency and inpatient hospital services. Emergency and inpatient hospital services are covered when medically necessary for the active medical treatment of the acute phases of alcohol withdrawal (detoxification), for stabilization, and for treatment of medical complications of alcoholism. Emergency and inpatient hospital services are considered medically necessary **only** when the patient's condition is such that the personnel and facilities of a hospital are required. Stays provided for alcohol rehabilitation in a hospital-based rehabilitation facility are covered, subject to the provisions of paragraph E.4.b. of this chapter. Inpatient hospital services also are subject to the provisions regarding the limit on inpatient mental health services.

b. Authorized alcoholism treatment. Only those services provided in an organized alcoholism treatment program, **by** an authorized free-standing or hospital-based alcohol rehabilitation facility are covered. Covered services consist of any or all of the services listed below. A qualified mental health provider (physicians, clinical psychologists, clinical social workers, psychiatric nurse specialists) (see paragraph C.3.i.) shall prescribe the particular level of treatment. Each CHAMPUS beneficiary is entitled to three alcoholism treatment benefit periods in his or her lifetime. (A benefit period begins with the first date of covered alcoholism treatment and ends 365 days later, regardless of the total services actually used within the benefit period. Unused benefits cannot be carried over to subsequent benefit periods. Emergency and inpatient hospital " services (as described in paragraph E.4.a. of this chapter) do not constitute alcoholism treatment for purposes of establishing the beginning of a benefit period. )

(1) Rehabilitative care. Rehabilitative care in an authorized alcohol rehabilitation facility, whether free-standing or hospital-based, is covered on either a residential or partial care (day or night program) basis. Coverage during a single benefit period is limited to no more than one inpatient stay (exclusive of stays classified in DRG 433) in hospitals subject to the CHAMPUS **DRG-based** payment system or 21 days in a DRG-exempt facility for rehabilitative care. If the patient is medically in need of alcohol detoxification, but does not require the personnel or facilities of a general hospital setting, detoxification services are covered in addition to the rehabilitative care, but in a DRG-exempt facility detoxification services are limited to 7 days. The medical necessity for the detoxification must be documented. Any detoxification services provided **by** the alcohol rehabilitation facility must be under general medical supervision.

(2) Outpatient care. Outpatient treatment provided by an approved alcohol rehabilitation facility, whether free-standing or hospital-based; is covered for up to 60 visits in a benefit period.

(3) Family therapy. Family therapy provided by an approved alcohol rehabilitation facility, whether free-standing or hospital-based, is covered for up to 15 visits in a benefit period.

c. Exclusions

(1) Aversion therapy. The programmed use of physical measures, such as electric shock, alcohol, or other drugs as negative reinforcement (aversion therapy) is not covered, even if recommended by a physician.

(2) Domiciliary settings. Domiciliary facilities, "generally referred to as halfway or quarterway houses, are not authorized providers and charges for services provided by these facilities are not covered.

d. Confidentiality. Release of any patient identifying information, including that required to adjudicate a claim, must comply with the provisions of section 523 of the Health Service Act (HSA), as amended, (42 U.S.C. 290dd- 3), which governs the release of medical and other information from the records of patients undergoing treatment of alcoholism. If the patient refuses to authorize the release of medical records which are, in the opinion of the Director, OCHAMPUS, or a designee, necessary to determine benefits on a claim for treatment of alcoholism, the claim will be denied.

5. Organ transplants. Basic Program benefits are available for otherwise covered services or supplies in connection with an organ transplant procedure, provided such transplant procedure generally is in accordance with accepted professional medical standards and is not considered to be experimental or investigational.

a. Recipient costs-. CHAMPUS benefits are payable for recipient costs when the recipient of the transplant is a beneficiary, whether or not the donor is a beneficiary.

b. Donor costs

(1) Donor costs are payable when both the donor and recipient are CHAMPUS beneficiaries.

(2) Donor costs are payable when the donor is a CHAMPUS beneficiary but the recipient is not.

(3) Donor costs are payable when the donor is the sponsor and the recipient is a beneficiary. (In such an event, donor costs are paid as a part of the beneficiary and recipient costs.)

(4) Donor costs also are payable when the donor is neither a CHAMPUS beneficiary nor a sponsor, if the recipient is a CHAMPUS beneficiary. (Again, in such an event, donor costs are paid as a part of the beneficiary and recipient costs.)

c. General limitations

(1) If the donor is not a beneficiary, CHAMPUS benefits for donor costs are limited to those directly related to the transplant procedure itself and do not include any medical care costs related to other treatment of the donor, including complications.

(2) In most instances, for costs related to kidney transplants, Medicare (not CHAMPUS) benefits will be applicable. If a CHAMPUS beneficiary participates as a kidney donor for a Medicare beneficiary, Medicare will pay for expenses in connection with the kidney transplant to include all reasonable preparatory, operation and postoperation **recovery** expenses associated with the **donation** (postoperative recovery expenses are limited to the actual period of recovery) . (Refer to paragraph E.3.f. of Chapter 3 of this Regulation. )

(3) Donor transportation costs are excluded whether or not the donor is a beneficiary.

(4) When the organ transplant. is performed under a study, grant, or research program, no CHAMPUS benefits **are** payable for either recipient or donor cost.

d. Kidney acquisition. With specific reference to acquisition costs for kidneys, **each hospital** that performs kidney transplants is required **for** Medicare purposes to develop for **each** year separate **standard** acquisition costs for kidneys obtained from live donors and kidneys obtained from cadavers. The standard acquisition cost for cadaver kidneys is compiled **by** dividing the total cost of cadaver kidneys acquired **by** the number of transplants using cadaver kidneys. The standard acquisition cost for kidneys from live donors is compiled similarly using the total acquisition cost of kidneys from live donors and the number of transplants using kidneys from live donors. All recipients of cadaver kidneys are charged the same **standard** cadaver kidney acquisition cost and all recipients of kidneys from live donors are charged the same standard live donor acquisition cost. The appropriate hospital standard kidney acquisition costs (live donor or cadaver) required for Medicare in every instance must be used as the acquisition **cost** for purposes of providing CHAMPUS benefits.

e. Liver transplants. Effective July 1, 1983, CHAMPUS benefits are payable for services and supplies related to liver transplantation under the following circumstances only:

(1) Medical indications for liver t.ransplantation. CHAMPUS **shall** provide benefits for services and supplies related to liver transplantation performed for beneficiaries suffering from irreversible liver injury who have exhausted alternative medical and surgical treatments, who are approaching the terminal phase of their illness, and who are considered appropriate for liver transplantation according to guidelines adopted by the Director, OCHAMPUS.

(2) Contraindications. CHAMPUS shall not provide coverage if any of the following contraindications exist:

(a) Active alcohol or other substance abuse;

(b) Malignancies metastasized to or extending beyond the margins of the liver; or



Jul 91

(c) Viral-induced liver disease when **viremia** is still present.

(3) Specific covered services. CHAMPUS shall provide coverage for the following services related to **liver** transplantation:

(a) Medically necessary services to evaluate a potential **candidate's** suitability for liver **transplantation**, whether or not **the** patient is ultimately accepted as a candidate for transplantation;

(b) Medically necessary **pre-** and post-transplant inpatient hospital and outpatient services;

(c) Surgical services and related **pre-** and post-operative services of the transplant team;

(d) Services provided by a donor organ acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center;

(e) Medically necessary services required to maintain the viability of the donor organ following a formal declaration of brain death and after all existing legal requirements for excision of the donor organ have **been** met;

(f) Blood and blood products;

(g) Services and drugs required for **immunosuppression**, provided the drugs are approved by the United States Food and **Drug** Administration;

(h) Services and supplies, including inpatient care, which are medically necessary to treat complications of the transplant procedure, including management of infection and rejection episodes; and

(i) Services and supplies which are medically necessary for the periodic evaluation and assessment of the successfully transplanted patient.

(4) Specific **noncovered** services. CHAMPUS benefits will not be paid for the following:

(a) Services and supplies for which the beneficiary has no legal obligation to pay. For example, CHAMPUS shall not reimburse expenses that are waived by the transplant center, or for which research funds are available; and

(b) Out-of-hospital living expenses and any **other** non-medical expenses, including transportation, of the liver transplant candidate **or** family members, whether **pre-** or post-transplant.

(5) Implementation guidelines. The Director, **OCHAMPUS**, shall issue such guidelines as are necessary to implement the provision of this paragraph.

f. Heart Transplantation. CHAMPUS benefits are payable for services and supplies related to heart transplantation under the following circumstances:

(1) Medical indications for heart transplantation. CHAMPUS shall provide benefits for services and supplies related to heart transplantation performed for beneficiaries with **end-stage** cardiac disease who have exhausted alternative medical and surgical treatments, who have a very poor prognosis as a result of poor cardiac functional status, for whom plans for long-term adherence to a disciplined **medical regimen** are feasible, and who are considered appropriate for heart transplantation according to guidelines adopted by the Director, **OCHAMPUS**. However, benefits for heart transplantation are available only if the procedure is performed in a CHAMPUS-approved heart transplantation center or meets other certification or accreditation standards recognized by the Director, **OCHAMPUS**. See Chapter 6, paragraph B.4.c. of this Regulation.

(2) Specific covered services. CHAMPUS shall provide coverage for the following services related to heart transplantation:

(a) Medically necessary services to evaluate a potential candidate's suitability for heart transplantation, whether or not the patient is ultimately accepted as a candidate for transplantation;

(b) Medically necessary pre- and post-transplant inpatient hospital and outpatient services;

(c) Surgical services and related pre- and post-operative services of the transplant team;

(d) Services provided by the donor acquisition team, including the costs of transportation to the location of the donor organ and transportation of the team and the donated organ to the location of the transplantation center;

(e) Medically necessary services required to maintain the viability of the donor organ following a formal declaration of brain death and after all existing legal requirements for excision of the donor organ have been met;

(f) Blood and blood products;

(g) Services and drugs required for immunosuppression, provided the drugs are approved by the United States Food and Drug Administration;

(h) Services and supplies, including inpatient care, which are medically necessary to treat complications of the transplant procedure, including management of infection and rejection episodes; and

Jul 91

(i) Services and supplies which are medically necessary for the **periodic** evaluation and assessment of the successfully transplanted patient.

(3) Noncovered services. CHAMPUS benefits **will** not be paid for the following:

(a) Services and supplies for which the beneficiary has no legal obligation to pay; and

(b) Out-of-hospital living expenses and any other non-medical expenses, including transportation of the heart transplant candidate or **family** members, whether **pre-** or post-transplant.

(4) Implementation guidelines. The Director, **OCHAMPUS**, shall issue such guidelines as are necessary to implement the provisions of this paragraph.

6. Eyeglasses, spectacles, contact lenses, or other optical devices"  
Eyeglasses, spectacles, contact lenses, or other optical devices are excluded under the Basic Program except under very limited and specific circumstances.

a. Exception to general exclusion. Benefits for glasses and lenses may be extended **only in connection** with the following specified eye conditions and circumstances:

(1) Eyeglasses **or** lenses that perform the function of the human lens, lost as the result of intraocular surgery or ocular injury or congenital **absence**.

NOTE : Notwithstanding the general requirement for U.S. Food and Drug Administration approval of any surgical implant set forth in paragraph D.3.g. of this chapter, intraocular lenses are authorized under CHAMPUS if they are either approved for marketing by the FDA or are subject to an investigational device exemption.

( 2 ) "**Pinhole**" glasses prescribed for use after surgery for detached retina.

(3) Lenses prescribed as "treatment" instead of surgery for the following conditions:

(a) Contact lenses used for treatment of infantile glaucoma,

(b) **Corneal** or **scleral** lenses prescribed in connection with treatment of keratoconus.

(c) **Scleral** lenses prescribed to **retain** moisture when normal tearing is not present or is inadequate.

(d) **Corneal** or **scleral** lenses prescribed to reduce a **corneal** irregularity other than astigmatism.

b. Limitations. The specified benefits are limited further to one set of lenses related to one of the qualifying eye conditions set forth in paragraph E.6.a., above. If there is a prescription change requiring a new set of lenses (but still related to the qualifying eye condition), benefits may be extended for a second set of lenses, subject to specific medical review.

7. Transsexualism or such other conditions as gender dysphoria. All services and **supplies** directly or indirectly related to transsexualism or such other conditions as gender dysphoria are excluded under CHAMPUS. This exclusion includes, but is not limited to, psychotherapy, prescription drugs, and intersex surgery that may be provided in connection with transsexualism or such other conditions as gender **dysphoria**. There is only one very limited exception to this general exclusion, that is, notwithstanding the definition of congenital anomaly, **CHAMPUS** benefits may **be** extended for surgery and related medically necessary services performed to correct sex gender confusion (that is, ambiguous genitalia) which has been documented to be present at birth.

8. Cosmetic, reconstructive, or plastic surgery. For the purposes of CHAMPUS, cosmetic, reconstructive, or plastic surgery is surgery that can **be** expected primarily to improve physical appearance or that is performed primarily for psychological purposes or that restores form, but does not correct or improve materially a bodily function.

NOTE : If a surgical procedure primarily restores function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subsection E.8.

Jul 91

a. Limited benefits under CHAMPUS. Benefits under the Basic Program generally are not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances, benefits for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

- (1) Correction of a congenital anomaly; or
- (2) Restoration of body form following an accidental injury; or
- (3) Revision of disfiguring **and** extensive scars resulting from **neoplastic** surgery.
- (4) Reconstructive breast surgery following a medically necessary mastectomy performed for the treatment of carcinoma, severe fibrocystic disease, other nonmalignant tumors or traumatic injuries.
- (5) Penile implants and testicular prostheses for conditions resulting from organic origins (i.e., trauma, **radical** surgery, disease process, for correction of congenital anomaly, etc.). Also penile implants **for** organic impotency.

NOTE :       Organic impotence is defined as that which can be reasonably expected to occur following certain diseases, surgical procedures, trauma, injury, or congenital malformation. Impotence does not become organic because of psychological or psychiatric reasons.

(6) Generally, benefits are limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than December 31 of the year following the year in which the related accidental injury or surgical trauma occurred, except for authorized postmastectomy breast reconstruction for which there is no time limitation between mastectomy and reconstruction. **Also**, special consideration for exception will be given to cases involving children who may require a growth period.

b. General exclusions

(1) For the purposes of CHAMPUS, dental congenital anomalies such as absent tooth buds or malocclusion specifically are excluded. Also excluded are any procedures related to transsexualism or such other conditions as gender dysphoria except as provided in subsection E.7., above.

(2) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process also are excluded.

(3) Procedures performed for elective correction of minor dermatological blemishes and marks or minor anatomical anomalies also are excluded.

(4) In addition, whether or not it would otherwise qualify for benefits under paragraph **E.8.a.**, above, the breast augmentation **mammoplasty** is specifically excluded.

c. Noncovered surgery, all related services and **supplies** excluded.  
**When it is determined** that a cosmetic, **reconstructive**, or plastic surgery procedure does not qualify for CHAMPUS benefits,- all related services and supplies are excluded, including any institutional costs.

d. Examples of **noncovered** cosmetic, reconstructive, or plastic surgery procedures. The following is a partial list of cosmetic, reconstructive, or plastic surgery procedures that do not qualify for benefits under CHAMPUS. This **list is** for example purposes only and is **not to be** construed as being all-inclusive.

(1) Any procedure performed for personal reasons to improve the appearance of an obvious feature "or part of the body that would **be** considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures that are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation **mammoplasties**, except for those performed as a part of postmastectomy breast reconstruction as specifically authorized in subparagraph **E.8.a.** (4) of this chapter.

(4) Face lifts and other procedures related to the aging process.

(5) Reduction **mammoplasties** (unless there is medical documentation of intractable pain, not amenable to other forms of treatment, resulting from large, pendulous breasts).

(6) Panniculectomy; body sculpture procedures.

(7) Repair of sagging eyelids (without demonstrated **and** medically documented significant impairment of vision).

"(8) Rhinoplasties (without evidence of accidental injury occurring within the previous 6 months that resulted in significant obstruction of breathing).

(9) Chemical peeling for facial wrinkles.

(10) **Dermabrasion** of the face.

(11) Elective correction of minor **dermatological** blemishes and marks or minor anatomical anomalies.

(12) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from **neoplastic** surgery.

(13) Removal of tattoos.

(14) Hair transplants.

(15) Electrolysis.

(16) Any procedures related to transsexualism or such other conditions as gender **dysphoria** except as provided in subsection E.7. of this chapter.

(17 Penile implant procedure for psychological impotency, transsexualism or such other conditions as gender **dysphoria**.

(18) Insertion of **prosthetic** testicles for transsexualism or such other conditions as gender **dysphoria**.

9. Complications (unfortunate **sequelae**) resulting from none.covered initial surgery or treatment. Benefits are available for **otherwise** covered services and supplies required in the treatment of complications resulting **from a** noncovered incident of treatment (such as nonadjunctive dental care, transsexual surgery, and cosmetic surgery) but only if the later complication represents a separate medical condition such as a systemic infection, cardiac arrest, and acute drug reaction. Benefits may not be ext.ended for any later care or procedures related to the complication that. essentially is similar to the initial **noncovered** care. Examples of complications similar to the initial episode of care (and thus not covered) would be repair of facial scarring resulting from dermabrasion for acne or repair of a **prolapsed** vagina in a biological male who had undergone transsexual surgery.

10. Dental. CHAMPUS does not include a dental benefit. Under very limited circumstances, benefits are available for dental services and supplies when the dental services are adjunctive to otherwise covered medical treatment.

a. Adjunctive dental care~~limited~~. Adjunctive dental care is limited to those services and supplies provided under the following conditions:

(1) Dental care which is medically necessary in the t.reatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition and is essential to the control of the primary medical condition. The following is a list of conditions for which CHAMPUS benefits are payable under this provision:

(a) Intraoral abscesses which extend beyond the dental alveolus.

(b) **Extraoral** abscesses.

(c) **Cellulitis** and **osteitis** which is clearly exacerbating and directly affecting a medical condition currently under treatment.

(d) Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accidental injury.

(e) **Myofacial** Pain Dysfunction Syndrome.

(f) Total or complete **ankyloglossia**.

(g) Adjunctive dental and orthodontic support for cleft palate.

(h) The prosthetic replacement of either the maxilla or the mandible due to the reduction of body tissues associated with traumatic injury (e.g., impact, gun shot wound), in addition to services related to treating **neoplasms** or iatrogenic dental trauma.



NOTE : The test of whether dental trauma is covered is whether the trauma is solely dental trauma. Dental trauma, in order to be covered, must be related to, and an integral part of medical trauma; or a result of medically necessary treatment of an injury or disease.

(2) Dental care required in preparation for medical treatment of a disease or disorder or required as the **result of** dental trauma caused by the medically necessary treatment of an injury or disease (iatrogenic).

(a) Necessary dental care including prophylaxis and extractions when performed in preparation for or as a result of in-line radiation therapy for oral or facial cancer.

(b) Treatment of gingival **hyperplasia**, with or without periodontal disease, as a direct result of prolonged therapy with **Dilantin (diphenylhydantoin)** or related compounds.

(c) Dental care is limited to the above and similar conditions specifically prescribed by the Director, **OCHAMPUS**, as meeting the requirements for coverage under the provisions of this section.

**b. General exclusions.**

(1) Dental care which is routine, preventative, restorative, **prosthodontic**, periodontics or emergency does not qualify as **adjunctive** dental care for the purposes of CHAMPUS except when performed in preparation for or as a result of dental trauma caused by medically necessary treatment of an injury or disease.

(2) The adding or modifying of bridgework and dentures.

(3) Orthodontia, except when directly related to and an integral part of the medical or surgical correction of a cleft palate or when required in preparation for, or as a result of, trauma to the teeth and supporting structures caused by medically necessary treatment of an injury or disease.

c. **Preauthorization required.** In order to be covered, **adjunctive** dental care requires preauthorization from the Director, **OCHAMPUS**, or a designee, in accordance with subsection A.11. of this chapter. When adjunctive dental care involves a medical (not dental) emergency (such as facial injuries resulting from an accident), the requirement for preauthorization is waived. Such waiver, however, is limited to the essential adjunctive dental care related to the medical condition requiring the immediate emergency treatment. A complete explanation, with supporting medical documentation, must be submitted with claims for emergency adjunctive dental care.

d. **Covered oral surgery.** Notwithstanding the above limitations on dental care, there are certain oral surgical procedures that are performed by both physicians and dentists, and that are essentially medical rather than dental care. For the purposes of CHAMPUS, the following procedures, whether performed by a

Jul 91

physician or dentist, are considered to be in this category and benefits may be extended for otherwise covered services and supplies without **preauthorization**:

(1) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, and roof and floor of the mouth, when such conditions require a **pathological** (histological) examination.

(2) Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, and roof and floor of the mouth.

(3) Treatment of oral or facial cancer.

(4) Treatment of fractures of facial bones.

(5) External (extra-oral) incision and drainage of **cellulitis**.

(6) Surgery of accessory sinuses, salivary glands, or ducts.

(7) Reduction of dislocations and the excision of the **temporomandibular** joints, when surgery is a necessary part of the reduction.

(8) Any oral surgical procedure that falls within the cosmetic, reconstructive, or plastic surgery definition is subject to the limitations and requirements set forth in subsection E.8. of this chapter.

**NOTE:** Extraction of unerupted or partially erupted, **malposed** or impacted teeth, with or without the attached **follicular** or development tissues, is not a covered oral surgery procedure except when the care is indicated in preparation for medical treatment of a disease or disorder or required as a result of dental trauma caused by the necessary medical treatment of an injury or illness. Surgical preparation of the mouth for dentures is not covered by CHAMPUS .

e. Inpatient hospital stay in connection with nonadjunctive, noncovered dental care. Institutional benefits specified in section B. of this chapter may be extended for inpatient hospital stays related to noncovered, nonadjunctive dental care when such inpatient stay is medically necessary to safeguard the life of the patient from the effects of dentistry because of the existence of a specific and serious nondental organic impairment currently under active treatment. (Hemophilia is an example of a condition that could be considered a serious nondental impairment. ) Preauthorization by the Director, **OCHAMPUS**, or a designee, is required for such inpatient stays to be covered in the same manner as required for **adjunctive** dental care described in paragraph E.10.C. of this chapter. Regardless of whether or not the preauthorization request for the hospital admission is approved and thus qualifies for institutional benefits, the professional service related to the nonadjunctive dental care is not covered.

Jul 91

**11. Drug abuse.** Under the Basic Program, benefits may be **extended** for medically necessary prescription drugs required in the treatment of an illness or injury or in connection with maternity care (refer to section D. of this chapter). However, CHAMPUS benefits cannot be **authorized** to support **or** maintain an existing or potential drug abuse situation, whether or not the drugs (under other circumstances) are eligible for benefit consideration and whether or not obtained by legal means.

a. Limitations on who can prescribe drugs. CHAMPUS benefits are not **available** for any drugs prescribed by a member of the beneficiary's family or **by** a **nonfamily** member residing in the same household with the beneficiary or sponsor.

b. Drug maintenance programs excluded. Drug maintenance programs when one addictive drug is substituted for another on a maintenance basis (such as methadone substituted for heroin) are not covered. This exclusion applies even in areas outside the United States where addictive drugs are dispensed legally by physicians on a maintenance dosage level.

c. Kinds of prescription drugs that are monitored carefully by CHAMPUS for possible abuse situations.

(1) Narcotics. Examples are Morphine and Demerol.

(2) Nonnarcotic analgesics. Examples are **Talwin** and **Darvon**.

(3) Tranquilizers. Examples are Valium, Librium, and **Meproamate**.

(4) Barbiturates. Examples are **Seconal** and **Nembutal**.

(5) Nonbarbiturate hypnotics. Examples are **Doriden** and **Chloral Hydrate**.

(6) Stimulants. Examples are amphetamines.

d. CHAMPUS fiscal intermediary responsibilities. CHAMPUS fiscal intermediaries are responsible for implementing utilization control and quality assurance procedures designed to identify possible drug **abuse** situations. The CHAMPUS fiscal intermediary is directed to screen all drug claims for potential overutilization and irrational prescribing of drugs, and to subject any such cases to extensive review to establish the necessity for the drugs and their appropriateness on the basis of diagnosis or definitive symptoms.

(1) When a possible drug abuse situation is identified, **all** claims for drugs for that specific beneficiary or provider will be suspended pending the results of a review.

(2) If the review determines that a drug abuse situation does in fact exist , all drug claims held in suspense will be denied.

(3) If the record indicates previously paid drug benefits, the prior claims for that beneficiary or provider **will** be reopened and the circumstances involved reviewed to determine whether or not drug abuse also existed at the time the earlier claims were adjudicated. If drug abuse is later ascertained, benefit payments made previously will be considered to have been extended in error and the amounts so paid recouped.

(4) Inpatient stays primarily for the purpose of obtaining drugs and any other services and supplies related to drug abuse also are excluded.

e. Unethical or illegal provider practices related to drugs. Any such investigation into a possible drug abuse that uncovers unethical or illegal drug dispensing practices on the part of an institution, a pharmacy, or physician will be referred to the professional or investigative agency having jurisdiction. CHAMPUS fiscal intermediaries are directed to **withhold** payment of all CHAMPUS claims for services and supplies rendered by a provider under active investigation for possible unethical or illegal drug dispensing activities.

f. Detoxification. The above monitoring and control of drug abuse situations shall in no way be construed to deny otherwise covered medical services and supplies related to drug detoxification (including newborn. addicted infants) when medical supervision is required.

12. Custodial care. The statute under which CHAMPUS operates specifically excludes custodial care. Many beneficiaries and sponsors misunderstand what is meant by custodial care, assuming that because custodial care is not covered, it implies the custodial care is not necessary. This is not the case; it only means the care being provided is not a type of care for which CHAMPUS benefits can be extended.

a. Kinds of "conditions that can result in custodial care. There is no absolute rule that can be applied. With most conditions, there is a period of active treatment before custodial care, some much more prolonged than others. Examples of potential custodial care cases may be a spinal cord injury resulting in extensive paralysis, a severe cerebral vascular accident, multiple sclerosis in its latter stages, or presenile and senile dementia. These conditions do not result necessarily in custodial care but are indicative of the types of conditions that sometimes do. It is not the condition itself that is controlling, but whether the care being rendered falls within the definition of custodial care (refer to Chapter 2 of this Regulation for the definition of "custodial care").

b. Benefits available in connection with a custodial care case. CHAMPUS benefits are not available for services related to a custodial care case, with the following specific exceptions:

(1) Prescription drugs and medicines, medical supplies and durable medical equipment. Benefits are payable for otherwise covered prescription drugs and medicines, medical supplies and durable medical equipment.

(2) Nursing services, limited. Recognizing that even though the care being received is determined primarily to be custodial, an occasional specific skilled nursing service may be required. When it is determined such skilled nursing services are needed, benefits may be extended for 1 hour of nursing care per day.

(3) Physician services, limited. Recognizing that even though the care being received is determined primarily to be custodial, occasional physician monitoring may be required to maintain the patient's condition. When it is determined that a patient is receiving custodial care, benefits may be extended for up to twelve physician visits per calendar year for the custodial condition (not to exceed one per month).

NOTE : CHAMPUS benefits may be extended for additional physician visits related to the treatment of a condition other than the condition for which the patient is receiving custodial care (an example is a broken leg as a result of a fall).

(4) Payment for prescription drugs, medical supplies, durable medical equipment and limited skilled nursing and physician services does not affect custodial care determination. The fact that CHAMPUS extends benefits for prescription drugs, medical supplies, durable medical equipment, and limited skilled nursing and physician services in no way affects the custodial care determination if the case otherwise falls within the definition of custodial care.

c. Exception to custodial care exclusion, admission to a hospital. CHAMPUS benefits may be extended for otherwise covered services or supplies directly , related to a medically necessary admission to an acute care general or special hospital (as defined in paragraph B.4 a., Chapter 6, of this Regulation), if the care is at the appropriate level and meets other requirements of this Regulation.

d. Reasonable care for which benefits were authorized or reimbursed before June 1, 1977. It is recognized that care for which benefits were authorized or reimbursed before the implementation date of the Regulation may be excluded under the custodial care limitations set forth in this Regulation. Therefore, an exception to the custodial care limitations set forth in this Regulation exists whereby reasonable care for which benefits authorized or reimbursed under the Basic Program before June 1, 1977, shall continue to be authorized even though the care would be excluded as a benefit under the custodial care limitations of the Regulation. Continuation of CHAMPUS benefits in such cases is limited as follows:

(1) Initial authorization or reimbursement before June 1, 1977. The initial CHAMPUS authorization or reimbursement for the care occurred before June 1, 1977; and,

(2) Continued care. The care has been continuous since the initial CHAMPUS authorization or reimbursement; and,

(3) Reasonable care. The care is reasonable. CHAMPUS benefits shall be continued for reasonable care up to the same level of benefits and for the same period of eligibility authorized or reimbursed before June 1, 1977. Care that is excessive or otherwise unreasonable will be reduced or eliminated from the continued care authorized under this exception.

13. Domiciliary care. The statute under which CHAMPUS operates also specifically excludes domiciliary care (refer to Chapter 2 of this Regulation for the definition of "Domiciliary Care").

a. Examples of domiciliary care situations. The following are examples of domiciliary care for which CHAMPUS benefits are not payable.

(1) Home care is not available. Institutionalization primarily because parents work, or extension of a hospital stay beyond what is medically necessary because the patient lives alone, are examples of domiciliary care provided because there is no other family member or other person available in the home.

(2) Home care is not suitable. Institutionalization of a child because a parent (or parents) is an alcoholic who is not responsible enough to care for the child, or because someone in the home has a contagious disease, are examples of domiciliary care being provided because the home setting is unsuitable.

(3) Family unwilling to care for a person in the home. A child who is difficult to manage may be placed in an institution, not because institutional care is medically necessary, but because the family does not want to handle him or her in the home. Such institutionalization would represent domiciliary care, that is, the family being unwilling to assume responsibility for the child.

Jul 91

b. Benefits available in connection with a domiciliary care case. Should the beneficiary receive otherwise covered medical services or supplies while also being in a domiciliary care situation, CHAMPUS benefits are payable for those medical services or supplies, or both, in the same manner as though the beneficiary resided in his or her own home. Such benefits would be cost-shared as though rendered to an outpatient.

c. General exclusion. Domiciliary care is institutionalization essentially to provide a **substitute** home--not because it is medically necessary for the beneficiary to be in the institution (although there may be conditions present that have contributed to the fact that domiciliary care is being rendered). CHAMPUS benefits are not payable for any costs or charges related to the provision of domiciliary care. While a substitute home or assistance may be necessary for the beneficiary, domiciliary care does not represent the kind of care for which CHAMPUS benefits can be provided.

#### 14. CT scanning

a. Approved CT scan services. Benefits may be extended for medically necessary CT scans of the head or other anatomical regions of the body when all of the following conditions are met:

(1) The patient is referred for the diagnostic procedure by a physician.

(2) The CT scan procedure is consistent with the preliminary diagnosis or symptoms.

(3) Other noninvasive and less costly means of diagnosis have been attempted or are not appropriate.

(4) The CT scan equipment is licensed or registered by the appropriate state agency responsible for licensing or registering medical equipment that emits ionizing radiation.

(5) The CT scan equipment is operated under the general supervision and direction of a physician.

(6) The results of the CT scan diagnostic procedure are interpreted by a physician.

b. Review guidelines and criteria. The Director, OCHAMPUS, or a designee, will issue specific guidelines and criteria for CHAMPUS coverage of medically necessary head and body part CT scans.

15. Morbid obesity. The CHAMPUS morbid obesity benefit is limited to the gastric bypass, gastric stapling, or gastroplasty method.

a. Conditions for coverage. Payment may be extended for the gastric bypass, gastric stapling, or gastroplasty method only when one of the following conditions is met:

(1) The patient is 100 **pounds** over the ideal weight for height and bone structure and has an associated severe medical condition. These associated medical conditions are diabetes **mellitus**, hypertension, **cholecystitis**, narcolepsy, **pickwickian** syndrome (and other **severe** respiratory diseases), hypothalamic disorders, and severe arthritis of the weight-bearing joints.

(2) The patient is 200 percent or more of the ideal weight for height and bone structure. An associated medical condition is not required for this category.

(3) The patient has had an intestinal bypass or other surgery for obesity and, because of complications, requires a second surgery (a takedown). The surgeon in many cases, will do a gastric bypass, gastric stapling, **or gastroplasty** to help the patient avoid regaining the weight that was lost. In this situation, **payment** is authorized even though the patient's condition technically may not meet the definition of morbid obesity because of the weight that was already lost following the initial surgery.

b. Exclusions

(1) CHAMPUS payment may not be made for nonsurgical treatment of obesity or morbid obesity, for dietary control, or weight reduction.

(2) CHAMPUS payment may not be made for surgical procedures other than the gastric bypass, gastric stapling, or **gastroplasty**, even if morbid obesity is present.

16. Maternity care.

a. Benefit. The CHAMPUS Basic Program may share the cost of medically necessary services and supplies associated with maternity care which are not otherwise excluded by this Regulation. However, failure by a beneficiary to secure a required **Nonavailability** Statement (**NAS**) (DD Form 1251) as set forth in subsection A. 9. of this Chapter will waive that beneficiary's right to CHAMPUS cost-share of certain maternity care services and supplies.

b. Cost-share. Subject to applicable NAS requirements, maternity care cost-share shall be determined as follows:

(1) Inpatient cost-share formula applies to maternity care ending in childbirth in, or on the way to, a hospital inpatient childbirth unit, and for maternity care ending in a non-birth outcome not otherwise excluded by this Regulation.

(2) Ambulatory surgery cost-share formula applies to maternity care ending in childbirth in, or on the way to, a birthing center to which the beneficiary is admitted and from which the beneficiary has received prenatal care, or a hospital-based outpatient birthing room.

(3) Outpatient cost-share formula applies to maternity care which terminates in a planned childbirth at home.

(4) Otherwise covered medical services and supplies directly related to "Complications of Pregnancy, " as defined in Chapter 2 will be cost-shared



on the same basis as the related maternity care for a period not to exceed 42 days following termination of the pregnancy and thereafter cost-shared on the basis of the inpatient or outpatient status of the beneficiary when medically necessary services and supplies are received.

17. Biofeedback Therapy. Biofeedback therapy is a technique by which a person is taught to exercise control over a physiologic process occurring within the body. By using modern biomedical instruments the patient learns how a specific physiologic system within his body operates and how to modify the performance of this particular system.

a. Benefits provided. CHAMPUS benefits are payable for services and supplies in connection with electrothermal, electromyograph and **electrodermal** biofeedback therapy when there is documentation that the patient has undergone an appropriate medical evaluation, that their present condition is not responding to or no longer responds to other forms of conventional treatment, and only when provided as treatment for the following conditions:

(1) Adjunctive treatment for Raynaud's Syndrome.

(2) Adjunctive treatment for muscle **re-education** of specific muscle groups or for treating pathological muscle abnormalities of **spasticity**, or incapacitating muscle-spasm or weakness.

b. Limitations. Payable benefits include initial intake evaluation. Treatment following the initial intake evaluation is limited to a maximum of 20 inpatient and outpatient biofeedback treatments per calendar year.

c. Exclusions. Benefits are excluded for biofeedback therapy for the treatment of ordinary muscle tension states or for psychosomatic conditions. Benefits are also excluded for the rental or purchase of biofeedback equipment.

d. Provider requirements. A provider of biofeedback therapy must be a CHAMPUS-authorized provider. (Refer to CHAPTER 6, "Authorized Providers.") If biofeedback treatment is provided by other than a physician, the patient must be referred by a physician.

e. Implementation Guidelines. The Director, OCHAMPUS, shall issue guidelines as are necessary to implement the provisions of this paragraph.

8. Cardiac Rehabilitation. Cardiac rehabilitation is the process by which individuals are restored to their optimal physical, medical and psychological status, after a cardiac event. Cardiac rehabilitation is often divided into three phases. Phase I begins during inpatient hospitalization and is managed by the patient's personal physician. Phase II is a medically supervised outpatient program which begins following discharge. Phase III is a lifetime maintenance program emphasizing continuation of physical fitness with periodic followup. Each phase includes an exercise component, patient education, and risk factor modification. There may be considerable variation in program components, intensity and duration.

a. Benefits Provided. CHAMPUS benefits are available on an inpatient or outpatient basis for services and supplies provided in connection with a cardiac rehabilitation program when ordered by a physician and provided as treatment for patients who have experienced the following cardiac events within the preceding **twelve** (12) months:

(1) **Myocardial Infarction.**

(2) Coronary Artery Bypass Graft.

(3) Coronary **Angioplasty.**

(4) Percutaneous **Transluminal** Coronary **Angioplasty.**

(5) Chronic Stable Angina (see limitations below).

b. Limitations. Payable benefits include separate allowance for the initial evaluation and testing. Outpatient treatment following the initial intake evaluation and testing is limited to a maximum of thirty-six (36) sessions per cardiac event, usually provided 3 sessions per week for **twelve** weeks, Patient's diagnosed with chronic stable angina are limited to one treatment episode (36 sessions) in a calendar year.

c. Exclusions. Phase III cardiac rehabilitation lifetime maintenance programs performed at home or in medically unsupervised settings are not covered.

d. Providers. A **provider** of cardiac rehabilitation services must be a CHAMPUS authorized hospital. (Refer to Chapter 6, "Authorized Providers.") All cardiac rehabilitation services must be ordered by a physician.

e. Payment. Payment for outpatient treatment will be based on an all inclusive allowable charge per session. Inpatient treatment will be paid based upon the reimbursement system in place for the hospital where the services are rendered.

f. Implemental-\$on Guidelines: The Director of **OCHAMPUS** shall issue guidelines as **are** necessary to implement the provisions of this paragraph.

#### F. BENEFICIARY OR SPONSOR LIABILITY

1. General. As stated in the introductory paragraph to this chapter, the **Basic** Program is essentially a supplemental program to the Uniformed Services direct medical care system. To encourage use of the Uniformed Services direct medical care system wherever its facilities are available and appropriate, the Basic Program benefits are designed ~~so that it is~~ to the financial advantage of a CHAMPUS beneficiary or sponsor to use the direct medical care system. When medical care is received from civilian sources, a CHAMPUS beneficiary is responsible for payment of certain deductible and cost-sharing amounts in connection with otherwise covered services and supplies. By statute, this joint financial responsibility between the beneficiary or sponsor and CHAMPUS is more favorable for dependents of active duty members than for other classes of beneficiaries.

Jul 91

2. Dependents of **active** duty **members** of the Uniformed Services. CHAMPUS beneficiary or sponsor liability set forth for dependents of active duty members is as follows:

a. Annual fiscal year deductible for outpatient services or **supplies**. A CHAMPUS beneficiary or sponsor is responsible **for** the payment of the first \$50 of the CHAMPUS-determined allowable costs or charges for otherwise covered outpatient services or supplies provided in any one fiscal year. However, when such outpatient services are provided to more than one beneficiary member

Jul 91

of a family during the same fiscal year, the aggregate outpatient deductible amount paid by any two or more beneficiary members of the family who submit claims may not exceed \$100 during any fiscal year.

(1) In any one fiscal year if only one beneficiary member of a family files a claim (regardless of the **number** of beneficiary members actually in the family), that beneficiary member is required only to satisfy a \$50 annual fiscal year deductible **for** outpatient services or supplies as described in paragraph **F.2.a.**, above.

(2) In any one fiscal year if two or more beneficiary members of a family file claims, the **total** amount of which is less than \$100 but none of the beneficiary members submit a claim for over \$50 dollars, no CHAMPUS benefits are payable for otherwise covered outpatient services or supplies provided such beneficiary members during that particular fiscal year.

(3) For any family the outpatient deductible amounts will be applied sequentially as the CHAMPUS claims are submitted.

(4) If the fiscal year outpatient deductible has been met by a beneficiary (\$50) or a family (\$100 aggregate) through the submission of a claim or claims to a CHAMPUS fiscal intermediary in another geographic location from the location where a current claim is being submitted, the beneficiary or sponsor must obtain a deductible certificate from the CHAMPUS fiscal intermediary where the applicable beneficiary or family fiscal year deductible was met.. Such deductible certificate must be attached to the current claim being submitted for benefits. Failure to obtain a deductible certificate under such circumstances will result in a second beneficiary or family fiscal year deductible being applied. However, this second deductible may be reimbursed once appropriate documentation, as described in this subparagraph **F.2.a. (4)**, is supplied to the CHAMPUS fiscal intermediary applying the second deductible (refer to section A. of Chapter 7 of this Regulation).

b.. Inpatient cost-sharing. Dependents of active duty members of the Uniformed Services or **their sponsors** are responsible for the payment of the first \$25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider (refer to Chapter 6 of this Regulation), or the amount the beneficiary or sponsor **would** have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater.

NOTE : The Secretary of Defense (after consulting with the Secretary of Health and Human Services and the Secretary of Transportation) prescribes the fair charges for inpatient hospital care provided through Uniformed Services medical facilities. This determination is made each fiscal year.

(1) Inpatient cost-sharing payable with each separate inpatient admission. A separate cost-sharing amount (as described in this subsection **F.2.**) is payable for each inpatient admission to a hospital or other authorized institution, regardless of the purpose of the admission (such as medical or surgical), regardless of the number of times the beneficiary is admitted,

and regardless of whether or not the inpatient admissions are for the same or related conditions; except, that successive inpatient admissions shall be deemed one inpatient confinement **for** the purpose of computing the inpatient cost-share payable, provided not more than 60 days have **e.lapsed** between the. successive admissions. However, notwithstanding this provision, all admissions related **to a single** maternity episode shall be considered one confinement, regardless of the number of days between admissions (refer to section B. of this chapter).

(2) **Multiple family inpatient admissions.** A separate cost-sharing amount is payable for each inpatient admission, regardless of whether or not two or more beneficiary members of a family are admitted at the same time or from the same cause (such as an accident). A separate beneficiary inpatient cost-sharing amount must be applied for each separate admission **on** each beneficiary member of the family.

(3) **Newborn patient in his or her own right.** When a newborn infant remains as an inpatient in his or her own right (usually after the mother is discharged), the newborn **child** becomes the beneficiary and patient and the extended inpatient stay becomes a separate inpatient admission. In such a situation, a new, separate inpatient cost-sharing amount is applied. If a multiple birth is involved (such as twins or triplets) and two or more newborn infants become patients in their own right, a separate inpatient cost-sharing amount must be applied to the inpatient stay for each newborn child who has remained as an inpatient in his or her own right.

c. **Outpatient cost-sharing.** Dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of 20 percent of the CHAMPUS-determined allowable cost or charge beyond the annual fiscal year deductible amount (as described in paragraph **F.2.a.** of this chapter) for otherwise covered services or supplies provided on an outpatient basis **by** authorized providers.

d. **Ambulatory surgery.** Notwithstanding the above provisions pertaining to outpatient cost-sharing, dependents of active duty members of the Uniformed Services or their sponsors are responsible for payment of \$25 for surgical care that is authorized and received while in an outpatient status and that has been designated in guidelines issued by the Director, **OCHAMPUS**, or a designee.

3. **Retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees.** CHAMPUS beneficiary liability set forth for retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees is as follows:

a. **Annual fiscal year deductible for outpatient services or supplies.** The **annual** fiscal year deductible for otherwise covered outpatient services or supplies provided retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased "retirees is identical to the annual fiscal yeas outpatient deductible applicable to dependents of active duty members (refer to paragraph **F.2.a.** of this chapter).

b. Inpatient cost-sharing. Cost-sharing amounts for inpatient services shall be as follows:

(1) Services subject to the CHAMPUS DRG-based payment system. The cost-share shall be the lesser of an amount calculated by multiplying a per diem amount for each day of the hospital stay except the day of discharge or 25 percent of the hospital's billed charges. The per diem amount shall be calculated so that total cost-sharing amounts for these beneficiaries is equivalent to 25 percent of the CHAMPUS-determined allowable costs for covered services or supplies provided on an inpatient basis by authorized providers. The per diem amount shall be published annually by CHAMPUS.

(2) Services subject to the mental health per diem payment system. The cost-share is dependent upon whether the hospital is paid a hospital-specific per diem or a regional per diem under the provisions of subsection A.2. of Chapter 14. With respect to care paid for on the basis of a hospital-specific per diem, the cost-share shall be 25% of the hospital-specific per diem amount. For care paid for on the basis of a regional per diem, the cost share shall be the lower of a fixed daily amount or 25% of the hospital's billed charges. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25 percent of total payments under the mental health per diem payment system. This fixed daily amount shall be updated annually and published in the Federal Register along with the per diems published pursuant to subparagraph A.2.d. (2) of Chapter 14.

(3) Other services. For services exempt from the CHAMPUS DRG-based payment system and the CHAMPUS mental health per diem payment system and services provided by institutions other than hospitals, the cost-share shall be 25% of the CHAMPUS-determined allowable charges.

c. Outpatient cost-sharing. Retirees, dependents of retirees, dependents of deceased active duty members, and dependent-s of deceased retirees are responsible for payment of 25 percent of the CHAMPUS-determined allowable costs or charges beyond the annual fiscal year deductible amount (as described in paragraph F.2.a. of this chapter)" for otherwise covered services or supplies provided on an outpatient basis by authorized providers.

4. Former spouses. CHAMPUS beneficiary liability set forth for former spouses eligible under the provisions of paragraph B.2.b. of Chapter 3 is as follows:

a. Annual fiscal year" deductible for outpatient services or supplies. An eligible former spouse is responsible for the payment of the first \$50 of-the CHAMPUS-determined reasonable costs or charges for otherwise covered outpatient services or supplies provided in any one fiscal year. The former spouse cannot contribute to, nor benefit from, any family deductible of the member or former member to whom the former spouse was married or of any CHAMPUS-eligible children.

b. Inpatient cost-sharing. Eligible former spouses are responsible for the payment of cost-sharing amounts the same as those required for

retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees.

c. Outpatient cost-sharing Eligible former spouses are responsible for payment of 25 percent of **the CHAMPUS-determined** reasonable costs or charges beyond the annual fiscal year deductible amount for otherwise covered services or supplies provided **on** an outpatient basis by authorized providers.

5. Cost-Sharing under the Military-Civilian Health Services Partnership Program. Cost-sharing is dependent upon the type of partnership program entered into, whether external or internal. (See section P. of Chapter 1, **for general** requirements of the Military-Civilian Health Services Partnership Program.)

a. External Partnership Agreement. Authorized costs associated with the use of the civilian facility will be financed through CHAMPUS under the normal cost-sharing and reimbursement procedures applicable under CHAMPUS.

b. Internal Partnership Agreement. Beneficiary cost-share under internal agreements will be the same as charges prescribed for care in military treatment facilities.

6. Amounts over CHAMPUS-determined allowable costs or charges. It is the **responsibility** of the CHAMPUS fiscal intermediary to determine allowable costs for services and supplies provided by hospitals and other institutions and allowable charges for services and supplies provided by physicians, other individual professional providers, and other providers. Such CHAMPUS-determined **allowable** costs or charges are made in accordance with the provisions of Chapter 14. **All** CHAMPUS benefits, including calculation of the CHAMPUS or beneficiary cost-sharing amounts, are based on such CHAMPUS-determined allowable costs or charges. The effect on the beneficiary when the billed cost or charge is over the CHAMPUS-determined allowable amount is dependent upon whether or not the applicable **claim was** submitted on a participating basis on behalf of the beneficiary or submitted directly by the beneficiary on a nonparticipating basis and on whether the claim is for inpatient hospital services subject to the CHAMPUS **DRG-based** payment system. This provision applies to all classes of CHAMPUS beneficiaries.

NOTE : When the provider "forgives" or "waives" any beneficiary liability, such as amounts applicable to the annual fiscal year deductible for outpatient services or supplies, or the inpatient or outpatient cost-sharing as previously set forth in this section, the CHAMPUS-determined allowable charge or cost allowance (whether payable to the CHAMPUS beneficiary or sponsor, or to a participating provider) shall be reduced by the same amount.

a. Participating provider. Under CHAMPUS, authorized professional providers and institutional providers other than hospitals have the option of participating on a claim-by-claim basis. Participation is required for inpatient claims only for hospitals which are Medicare-participating providers. Hospitals which are not Medicare-participating but which are subject to the CHAMPUS DRG-based payment system in subsection A1. of Chapter 14 must sign agreements to participate

on all CHAMPUS inpatient claims in order to be authorized providers under CHAMPUS. All other hospitals may elect to participate ~~on a~~ claim-by-claim basis. Participating providers must indicate participation ~~by~~ signing the appropriate space on the applicable CHAMPUS claim form ~~and~~ submitting it to the appropriate CHAMPUS fiscal intermediary. In the case of an institution or medical supplier, the claim must be signed ~~by~~ an official having such authority. This signature certifies that the provider has agreed" to accept the CHAMPUS-determined allowable charge or cost as payment in full, for the medical services and supplies listed on the specific claim form, and further has agreed to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-sharing amount paid by ~~or~~ on behalf of the beneficiary as full payment. for the covered medical services or supplies. Therefore, when costs or charges are submitted on a participating basis, the patient is not obligated to pay any amounts disallowed as being over the **CHAMPUS-determined** allowable cost or charge for authorized medical services or supplies.

**b** Nonparticipating providers. Nonparticipating providers are those providers who do not agree ~~on~~ the CHAMPUS claim form to participate and thereby do not agree to accept the CHAMPUS-determined allowable costs or charges as the full charge. For otherwise covered services ~~and~~ supplies provided by such nonparticipating CHAMPUS providers, payment is made directly to the beneficiary or sponsor and the beneficiary **is** liable under applicable law for any amounts over the **CHAMPUS-determined** allowable costs or charges. CHAMPUS shall have no responsibility for any amounts over allowable costs or charges as determined by CHAMPUS.

7. [Reserved]

8. Cost-sharing for services provided under special discount arrangements.

a. General rule. With respect to services determined by the Director, OCHAMPUS (or designee) to ~~be~~ covered by Chapter 14, section I., the Director, OCHAMPUS (or designee) has authority to establish, as an exception to the cost-sharing amount normally required pursuant to this chapter, a different cost-share amount that appropriately **reflects the** application of the statutory cost-share to the discount arrangement.

b. Specific applications. The following are examples of applications of the general ~~rule; they~~ are not **all** inclusive.

(1) In the case of services provided ~~by~~ individual **health** care professionals and other noninstitutional providers, the cost-share shall ~~be~~ the **usual** percentage of the **CHAMPUS allowable** charge determined under Chapter 14, section I.

(2) In the case of services provided ~~by~~ institutional providers normally paid on the basis of a pre-set amount (such as **DRG-based** amount under Chapter 14, section A1. or per-diem amount under Chapter 14, section A.2.), if the discount rate is lower than the pre-set rate, the cost-share amount that would apply for a beneficiary other than an active duty dependent pursuant to the normal pre-set rate would be reduced by the same percentage by which the pre-set rate was reduced **in** setting the discount rate.



G. EXCLUSIONS AND LIMITATIONS

In addition to any definitions, requirements, conditions, or limitations enumerated **and** described in other chapters of this Regulation, the following specifically are excluded from the Basic Program:

1. Not medically or psychologically necessary. Services and supplies that are not medically **or** psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder) or injury, for the diagnosis and treatment of pregnancy, or for well-baby care.

2. Unnecessary diagnostic tests. X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms.

3. Institutional level of care. Services and supplies related to inpatient stays in hospitals or other **authorized** institutions above the appropriate level required to provide necessary medical care.

4. Diagnostic admission. Services **and** supplies related to an inpatient admission **primarily** to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis.

NOTE : If it is determined that the diagnostic x-ray, laboratory, and pathological services and machine tests performed during such admission were medically necessary and would have been covered if **performed** on an outpatient basis, CHAMPUS benefits may be extended for such diagnostic procedures only, but cost-sharing will **be** computed as if performed **on** an outpatient basis.

5. Unnecessary postpartum inpatient stay, mother or newborn. Postpartum inpatient stay of a mother for purposes of staying with the newborn infant (usually primarily for the purpose of breast feeding the infant.) when the infant (lint. not the mother) requires the extended stay; or continued inpatient stay **of** a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay.

6. Therapeutic absences" Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by the Director, **OCHAMPUS**, or a designee. For cost-sharing provisions refer to Chapter 14, paragraph F.3.

7. Custodial care. Custodial care regardless of where rendered, except as otherwise specifically provided in paragraphs **E.12.b.** , **E.12.c.** and **E.12.d.** of this chapter.

8. Domiciliary care. Inpatient stays primarily for domiciliary care purposes.

9. Rest or rest cures. Inpatient stays primarily for rest or rest cures.

10. Amounts above allowable costs or charges. costs of services and supplies to the extent amounts billed are over the CHAMPUS determined allowable cost **or** charge, as provided for in Chapter 14.

11. No legal obligation to pay, no charge would be made Services or supplies for **which the** beneficiary or sponsor has no legal obligation to pay; or for which no charge **would** be made if the beneficiary or sponsor was not eligible under CHAMPUS; or whenever CHAMPUS is a secondary payer for claims subject to the CHAMPUS DRG-based payment system, amounts, when combined with the primary payment, which would be in excess of charges (or the amount the provider is obligated to accept as payment in full, if it is less than the charges).

12. Furnished without charge. Services or supplies furnished without charge.

13. Furnished by local, state, or Federal Government. Services and supplies paid for, or eligible for payment, directly or indirectly by a **local**, state, or Federal Government, except as provided under CHAMPUS, or by government hospitals **serving** the general public, or medical care provided by a Uniformed Service medical care facility, or benefits provided under title XIX of the Social Security Act (Medicaid') (reference (h)) (refer to Chapter 8 of this Regulation).

14. Study, grant, oror research programs. Services and supplies provided as a part of or under a scientific or medical study, grant, or research program.

15. Not in accordance with **accepted** standards, experimental or investigational. Services and supplies not provided in accordance with accepted professional medical standards; or related to essentially experimental or investigational procedures or treatment regimens.

16. **Immediate** family, household. Services or supplies provided or prescribed by a member of the beneficiary's immediate family, or a person living in the beneficiary's or sponsor's household.

17. Double coverage. Services and supplies that are (or are eligible to be) payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare (refer to Chapter 8 of this Regulation).

18. **Nonavailability** Statement **required.** Services and "supplies provided under circumstances or in geographic locations **requiring a Nonavailability** Statement (DD Form 1251), when such a statement was not obtained.

19. **Preauthorization required.** Services or supplies which require preauthorization if **preauthorization** was not obtained. Services and supplies which **were** not provided according to the terms of the preauthorization. The Director, **OCHAMPUS**, or a designee, may grant an exception **to** the requirement for preauthorization if the services otherwise would be payable except for the failure to obtain preauthorization.

20. **Psychoanalysis or psychotherapy, part of education.** Psychoanalysis or psychotherapy provided to a beneficiary **or** any member of the immediate family that is credited towards earning a degree or furtherance of the education or training of a beneficiary or sponsor, regardless of diagnosis or symptoms that may be present.

21. **Runaways.** Inpatient stays primarily to control or detain a runaway child, whether or not **admission** is to an authorized institution.

22. **Services or supplies ordered by a court or other government agency.** Services or supplies, including inpatient stays, directed or agreed to by a court or other governmental agency. However, those services and supplies (including inpatient stays) that otherwise are medically or psychologically necessary for the diagnosis or treatment of a covered condition and that otherwise meet **all** CHAMPUS requirements for coverage are not excluded.

23. **Work-related (occupational) disease or injury.** Services and supplies required as a result of occupational disease or injury for which any benefits are payable under a worker's compensation or similar law, whether or not such benefits have been applied for or paid; except if **benefits** provided under such laws are exhausted.

24. **Cosmetic, reconstructive, or plastic surgery.** Services and supplies in connection with cosmetic, reconstructive, or plastic surgery except as specifically provided in subsection E.8. of this chapter.

25. **Surgery, psychological reasons.** Surgery performed primarily for psychological reasons (such as psychogenic).

26. Electrolysis.

27. Dental care. Dental care or oral surgery, except as specifically provided in subsection E.10. of this chapter.

28. Obesity, weight reduction. Services and supplies related to obesity or weight reduction whether surgical or nonsurgical; wiring of the jaw or any procedure of similar purpose, regardless of the circumstances under which performed; except that benefits may be provided for the gastric bypass, gastric stapling, or **gastroplasty** procedures in connection with morbid obesity as provided in subsection E.15. of this chapter.

29. Transsexualism or such other conditions as gender dysphoria. Services and supplies related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in subsection E.7. of this chapter.

30. Therapy or counseling for sexual dysfunctions or sexual inadequacies. Sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy for mental disorders involving sex deviations (e.g., transvestic fetishism), or other similar services, and any supplies provided in connection with therapy for sexual dysfunctions or inadequacies.

31. Corns, calluses, and toenails. Removal of corns or **calluses** or trimming of toenails and other routine podiatry services, except those required as a result of a diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes.

32. Dyslexia.

33. Surgical sterilization, reversal. Surgery to reverse surgical sterilization procedures.

34. Noncoital reproductive procedures including artificial insemination, in-vitro fertilization, gamete intrafallopian transfer and all other such reproductive technologies. Services and supplies related to artificial insemination (including semen donors and semen banks), in-vitro fertilization, gamete **intrafallopian** transfer and all other **noncoital** reproductive technologies.

35. Nonprescription contraceptives.

36. Tests to determine paternity or sex of a child. Diagnostic tests to establish paternity of a child; or tests to determine sex of an unborn child.

37. Preventive care. Preventive care, such as routine, annual, or employment requested physical examinations; routine screening procedures; immunizations; except that the following are not excluded:

a. Well-baby care, including newborn examination, Phenylketonuria (PKU) testing and newborn circumcision.

b. Rabies shots.

c. Tetanus shot following an accidental injury.

d. Rh immune globulin.

e. Genetic tests as specified in paragraph E.3.b. of this chapter.

f. Immunizations and physical examinations provided when required in the case of dependents of active duty military personnel who are traveling outside the United States as a result of an active member's duty assignment and such travel is being performed under orders issued by a Uniformed Service.

38. Chiropractors and naturopaths. Services of chiropractors and naturopaths whether or not such services would be eligible for benefits if rendered by an authorized provider.

39. Counseling. Educational counseling, nutritional counseling, vocational counseling, and counseling for socio-economic purposes. Counseling services that are not medically necessary in the treatment of a diagnosed medical condition, e.g., diabetic self-education programs, stress management, life style modification, etc. Services provided by a marriage, family, pastoral or mental health counselor in the treatment of a mental disorder are covered only as specifically provided in Chapter 6. Services provided by alcoholism rehabilitation counselors are covered only when rendered in a CHAMPUS-authorized alcohol rehabilitation facility and only when the cost of those services is included in the facility's CHAMPUS-determined allowable cost-rate.

40. Acupuncture. Acupuncture, whether used as a therapeutic agent or as an anesthetic .

41. Hair transplants, wigs, or hairpieces

NOTE : In accordance with Section 744 of the DoD Appropriation Act for 1981 (reference (o)), CHAMPUS coverage for wigs or hairpieces is permitted effective December 15, 1980, under the conditions listed below. Continued availability of benefits will depend on the language of the annual DoD Appropriation Acts.

a. Benefits provided. Benefits may be extended, in accordance with the CHAMPUS-determined allowable charge, for one wig or hairpiece per beneficiary (lifetime maximum) when the attending physician certifies that alopecia has resulted from treatment of a malignant disease and the beneficiary certifies that a wig or hairpiece has not been obtained previously through the U.S. Government (including the Veterans Administration).

b. Exclusions. The wig or hairpiece benefit does not include coverage for the following:

(1) Alopecia resulting from conditions other than treatment of malignant disease.

(2) Maintenance, wig or hairpiece supplies, or replacement of the wig or hairpiece.

(3) Hair transplants or any other surgical procedure involving the attachment of hair or a wig or hairpiece to the scalp.

(4) Any diagnostic or therapeutic method or supply intended to encourage hair regrowth.

42. Education or training. Self-help, academic education or vocational training services and supplies, unless the provisions of Chapter 4, paragraph B.I.e., relating to general or special education, apply.

43. Exercise/Relaxation/Comfort Devices. Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items.

44. Exercise. General exercise programs, even if recommended by a physician and regardless of whether or not rendered by an authorized provider. **In** addition, passive exercises and range of motion exercises also are excluded, except when prescribed by a physician and rendered by a physical therapist concurrent to, and as **an** integral part of, a comprehensive program of physical therapy.

45. Audiologist, speech therapist. Services of an audiologist or speech therapist, except when prescribed by a physician and rendered as a part of treatment addressed to the physical defect **itself** and not to any educational or occupational deficit.

46. Vision care. Eye exercises or visual training (**orthoptics**).

47. Eye and hearing examinations. Eye and hearing examinations except as specifically provided in paragraph C.2.p. of this chapter or except when rendered in connection with medical or surgical treatment of a covered illness **or injury**. Vision and hearing screening in connection with well-baby care is not excluded.

48. Prosthetic devices. Prostheses, except. artificial limbs and eyes, or if an item is inserted surgically in the body as an integral part of a surgical procedure. **All** dental prostheses are excluded, except for those specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly.

49. Orthopedic shoes. Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including special-ordered, custom-made built-up shoes, or regular shoes later built up.

50. Eyeglasses. Eyeglasses, spectacles, contact lenses, or other optical devices, except **as specifically** provided under subsection E.6. of this chapter.

51. Hearing aids. Hearing aids or other auditory sensory enhancing devices.

52. Telephonic services. Services or advice rendered by telephone or other telephonic device, including remote monitoring, except for transtelephonic monitoring of cardiac pacemakers.

53. Air conditioners, humidifiers, dehumidifiers, and purifiers.
54. Elevators or chair lifts.
55. Alterations. Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.
56. Clothing. Items of clothing or shoes, even if required by virtue of an allergy (**such** as cotton fabric as against synthetic fabric **and** vegetable dyed shoes ) .
57. Food, food substitutes. Food, food **substitutes**, vitamins, or other nutritional supplements, including those related to prenatal care.
58. Enuresis. Enuretic devices; enuretic conditioning programs.
59. RESERVED.
60. Autopsy and postmortem.
61. Camping. All camping even though organized for a specific therapeutic purpose (such as diabetic camp or a camp for emotionally disturbed children), and even though offered as a part of an otherwise covered treatment plan or offered through a CHAMPUS-approved facility.
62. Housekeeper, companion. Housekeeping, homemaker, or attendant services; sitter or companion.
63. Noncovered condition, unauthorized provider. All services and supplies (including inpatient institutional costs) related to a noncovered condition or treatment, or provided by an unauthorized provider.
64. Comfort or convenience. Personal, comfort, or convenience items such as beauty and barber services, radio, television, and telephone.
65. "stop smoking" programs. Services and supplies related to "stop smoking" regimens.
66. Megavitamin psychiatric therapy, orthomolecular psychiatric therapy.
67. Transportation. All transportation except by ambulance, as specifically provided under section D. of this chapter, and except as authorized in subsection E.5. of this chapter.
68. Travel. All travel even though prescribed by a physician and even if its purpose is to obtain medical care, except as specified in subsection A.6. of this chapter in connection with a CHAMPUS-required physical examination.
69. Institutions Services and supplies provided by other than a hospital, unless the institution has been approved specifically by OCHAMPUS. Nursing homes, intermediate care facilities, halfway houses, homes for the aged, or institutions of similar purpose are excluded from consideration as approved facilities under the Basic Program.

Jul 91

NOTE : In order to be approved under CHAMPUS, an institution must, in addition to meeting CHAMPUS standards, provide a level of care for which CHAMPUS benefits are payable.

70. Supplemental diagnostic services. Diagnostic services including clinical laboratory examinations, x-ray examinations, pathological examinations, and machine tests that produce hard-copy results performed by civilian providers at the request of the attending Uniformed Service medical department physician (active duty or civil service).

71. supplemental consultations. Consultations provided by civilian providers at the request of the attending Uniformed Services medical department physician (active duty or civil service).

72. Inpatient mental health services. More than 60 days of inpatient. mental health services in any calendar year unless additional coverage is granted by the Director, OCHAMPUS, or a designee, in accordance with paragraph B.5.i. of this chapter. This exclusion does not apply to services provided under the provisions of Chapter 5 of this Regulation; services provided on less than a 24-hour-a-day basis; or services provided in a CHAMPUS-authorized residential treatment center that meets the requirements of paragraph B.4.e. of Chapter 6, of this Regulation.

73. Not specifically listed. Services and supplies not specifically listed as a benefit in this Regulation. This exclusion is not intended to preclude extending benefits for those services or supplies specifically determined to be covered within the intent of this Regulation by the Director, OCHAMPUS, or a designee, even though not otherwise listed.

NOTE : The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge an allowable expense, even though it is not listed specifically as an exclusion.

#### H. Payment and liability for certain potentially excludable services under the Peer Review Organization program.

1. Applicability. This section provides special rules that apply only to services retrospectively determined under the Peer Review Organization (PRO) program (operated pursuant. to Chapter 15) to be potentially excludable (in whole or in part) from the Basic Program under section G. of this chapter. Services may be excluded by reason of being not medically necessary (subsection G.1.) at an inappropriate level (subsection G.3.) custodial care (subsection G.7.) or other reason relative to reasonableness, necessity or appropriateness (which services shall throughout the remainder of this section, be referred to as "not medically necessary"). (Also throughout the remainder of the section, "services" includes items and "provider" includes supplier.) This section does not apply to coverage determinations made by OCHAMPUS or the fiscal intermediaries which are not based on medical necessity determinations made under the PRO program.

2. Payment for certain potentially excludable expenses. Services determined under the PRO program to be potentially excludable by reason of the exclusions in



section G. of this chapter for not medically necessary services will not be determined to be excludable if neither the beneficiary to whom the services were provided nor the provider (institutional or individual) who furnished the services knew, or could reasonably have been expected to know, that the services were subject to those exclusions. Payment may be made for such services as if the exclusions did not apply.

3. Liability for certain excludable services. In any case in which items or services are determined excludable by the PRO program by reason of being not medically necessary and payment may not be made under subsection H.Z., above because the requirements of subsection H.2. are not met, the beneficiary may not be held liable (and shall be entitled to a full refund from the provider of the amount excluded and any cost-share amount already paid) if:

a. The beneficiary did not know and could not reasonably have been expected to know that the services were excludable by reason of being not medically necessary; and

b. The provider knew or could reasonably have been expected to know that the items or services were excludable by reason of being not medically necessary.

4. Criteria for determining that beneficiary knew or could reasonably have been expected to have known that services were excludable. A beneficiary who receives services excludable by reason of being not medically necessary will be found to have known that the services were excludable if the beneficiary has been given written notice that the services were excludable or that similar or comparable services provided on a previous occasion were excludable and that notice was given by the OCHAMPUS, CHAMPUS PRO or fiscal intermediary, a group or committee responsible for utilization review for the provider, or the provider who provided the services.

5. Criteria for determining that provider knew or could reasonably have been expected to have known that services were excludable. An institutional or individual provider will be found to have known or been reasonably expected to have known that services were excludable under this section under any one of the following circumstances:

a. The PRO or fiscal intermediary had informed the provider that the services provided were excludable or that similar or reasonably comparable services were excludable.

b. The utilization review group or committee for an institutional provider or the beneficiary's attending physician had informed the provider that the services provided were excludable.

c. The provider had informed the beneficiary that the services were excludable .

d. The provider had received written materials, including notices, manual issuances, bulletins, guides, directives, or other materials, providing notification of PRO screening criteria specific to the condition of the beneficiary. Attending physicians who are members of the medical staff

of an institutional provider will, **be** found to have also received written materials "" provided to the institutional provider.

e. The services that are **at** issue are the subject of what are generally considered acceptable **standards** of practice **by** the local medical community.